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TRANSACTIONS

OF THE

AMERICAN HOSPITAL  
ASSOCIATION

Thirteenth Annual Conference

HELD AT NEW YORK CITY

SEPTEMBER 19, 20, 21, and 22, 1911

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(a) The Executive Committee will act as a Committee on local Arrangements for the Convention of 1912.

(b) This Committee is to report on or before Jan. 1st, 1914.

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Fourteenth Annual Conference to be held in Detroit,  
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\*Membership list by states follows alphabetical list.  
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La. The Ventosa, 1st and B. Sts., Washington, D.C.  
(*Associate.*)
- MISS ANNIE M. CASEY, Supt., (1907)  
German Hospital, Kansas City, Mo.
- T. D. CATLIN, Trustee, (1910-11)  
J. S. Ryburn Hospital, Ottawa, Ill.
- MISS JENNIE E. CATTON, Supt., (1910-11)  
Springfield Hospital, Springfield, Mass.

- M. CAVANA, M.D., Supt., (1909)  
Oneida Private Hospital, Sylvan Beach, N.Y.
- EMELEE M. CHABOT, Member, (1910)  
Fabiola Hospital, Oakland, Cal. (*Associate.*)
- C. T. CHAMBERLAIN, M.D., Supt., (1910-11)  
Chamberlain Sanitarium, Natchez, Miss.
- MISS EDNA L. CHAMBERS, Supt., (1908)  
Christ Hospital, Jersey City, N.J.
- MRS. MARY J. CHAMBERS, Supt., (1908)  
St. Luke's Hospital, St. Louis, Mo.
- MISS ANNA E. CHAPMAN, Supt., (1909)  
Emergency Hospital, Easton, Md.
- THOMAS J. CHARLTON, M.D., Supt., (1908)  
Savannah Hospital, Savannah, Ga.
- FREDERICK CHORMAN, Trustee, (1910-11)  
Memorial Hospital, Niagara Falls, N.Y.
- MISS CHARLOTTE CHRISTIAN, Supt., (1910)  
Passavant Memorial Hospital, Chicago, Ill.
- C. B. CLAPP, M.D., Supt., (1910-11)  
R. C. and Wabash Employees Hospital,  
Moberley, Mo.
- MRS. ETHEL P. CLARK, Supt., (1908)  
DeSoto Sanatorium, Jacksonville, Fla.
- J. CLEMENT CLARK, M.D., Supt., (1909)  
Springfield State Hospital, Sykesville, Md.
- C. B. CLARK, Trustee, (1910-11)  
Theda Clark Memorial Hospital, Neenah, Wis.
- MR. PLINY. O. CLARK, Supt., (1910-11)  
City Hospital, Wheeling, Va.
- A. E. CLEMENT, Trustee, (1910-11)  
Galloway Memorial Hospital, Nashville, Tenn.
- SISTER M. CLEMENT, Supt., (1910-11)  
St. Vincent de Paul Hospital, Brockville, Canada.
- GRACE L. CLOCK, Supt., (1910-11)  
Women's Hospital, 109th St., New York City.
- MISS MARY CLOMAN, Supt., (1910-11)  
Wesley Hospital, Atlanta, Ga.

- REV. GEO. F. CLOVER, Supt., (1907)  
St. Luke's Hospital, New York City.
- FARRAR COBB, M.D., Supt., (1905)  
Charitable Eye and Ear Hospital, Boston, Mass.
- O. H. COBB, Asst. Supt., (1910)  
New York State Hospital, Haverstraw, N.Y.  
(Associate.)
- J. R. CODDINGTON, Supt., (1900)  
Samaritan and Garretson Hospitals,  
Philadelphia, Pa.
- EDMUND D. CODMAN, Trustee, (1909)  
Peter Bent Brigham Hospital,  
27 Kilby St., Boston, Mass.
- MISS LAURA E. COLEMAN, Supt., (1905)  
Faulkner Hospital, Jamaica Plain, Mass.
- MISS LOUISE M. COLEMAN, Supt., (1905)  
Hospital of the Good Samaritan, Boston, Mass.
- M. COLLINS, M.D., Supt., (1903)  
National Jewish Hospital, Denver, Colo.
- HERBERT O. COLLINS, M.D., Supt., (1909)  
City Hospital, Minneapolis, Minn.
- ~~NEWTON C. COMFORT, Supt., (1910-11)~~  
~~Phillipine General Hospital, Manilla, P.I.~~
- WM. H. CONDON, Supt., (1909)  
German Hospital, Brooklyn, N.Y.
- W. H. CONLEY, Asst. Supt., (1910-11)  
Metropolitan Hospital, New York City.
- MISS MARGARET CONROY, Supt., (1910)  
St. Joseph's Hospital, Glace Bay, N.S., Canada.
- C. B. CONWELL, M.D., Supt., (1910-11)  
Ohio State Sanitarium, Mt. Vernon, O.
- J. W. COON, M.D., Supt., (1906)  
State Tuberculosis Hospital, Wales, Wis.
- R. W. CORWIN, M.D., Supt., (1910)  
Minnequa Hospital, Pueblo, Col.
- W. M. CORWIN, Trustee, (1910-11)  
German Hospital, Brooklyn, N.Y.



- J. M. COSGRAVE, Supt., (1905)  
Winnipeg Hospital, Winnipeg, Man.
- HENRY A. COTTON, M.D., Supt., (1909)  
New Jersey State Hospital, Trenton, N.J.
- SIMON F. COX, Supt.,  
Boston Consumptive Hospital, Boston, Mass.
- MISS EDITH I. COX, Supt., (1910-11)  
Faulkner Hospital, Jamaica Plains, Boston, Mass.
- MISS FRANCIS CRABTREE, (1909)  
Anna, Ill.
- MISS E. P. CRANDALL, (1903)  
257 W. 84th St., New York City.
- JOHN CROWE, Trustee, (1910-11)  
General Hospital, Guelph, Canada.
- MISS MARGARET M. CUMMINGS, Supt., (1909)  
Pittston Hospital, Pittston, Pa.
- MISS M. L. CUMMINS, Asst. Supt., (1911)  
Charter Oak Private Hospital, Hartford, Conn.
- LOUIS R. CURTIS, Supt., (1904)  
St. Luke's Hospital, Chicago, Ill.
- OCA CUSHMAN, Supt., (1910)  
Children's Hospital, Denver, Co.
- MRS. S. W. CUTLER, Supt., (1903)  
Danbury Hospital, Danbury, Conn.
- MISS AMELIA DAHLGREN, Supt., (1907)  
Englewood Hospital, Chicago, Ill.
- MISS ELIZABETH DALY, Supt., (1910)  
Infants' Summer Hospital, Charlotte, N.Y.
- HENRY G. DANFORTH, Trustee, (1909)  
Rochester General Hospital,  
Powers Bldg., Rochester, N.Y.
- MISS FLORA L. DANFORTH, Asst. Supt., (1909)  
Los Angeles Hospital, Los Angeles, Cal. (*Associate.*)
- A. F. DANILSON, Supt., (1911)  
Williamsburg Hospital, Brooklyn, N.Y.
- DANIEL C. DARROW, M.D., Supt., (1909)  
Darrow Hospital, Moorhead, Minn.

- WILLIAM DAUB, Supt., (1908)  
Lebanon Hospital, New York City.
- ALICE LOUISE DAVIS,  
(Address unknown.)
- MISS IDA E. DAVIS, Asst. Supt., (1909)  
Asheville, North Carolina.
- ELLA GREEN DAVIS, Supt., (1910)  
City Hospital, Owensboro, Ky.
- W. L. DEBOST, Trustee, (1910-11)  
S. R. Smith Infirmary, Tompkinville, N.Y.
- MISS M. DEFORD, M.D., (1909)  
Detroit, Mich.
- ROBT. DEFORD, Trustee, (1910-11)  
Presbyterian Hospital, New York City.
- MISS HANNA DEWEES, Supt., (1910-11)  
St. Peter's Hospital, Helena, Mont.
- DAVID N. DENNIS, M.D., Pres., Hospital Committee, (1908)  
Hamot Hospital, Erie, Pa.
- MISS F. E. DE LA MATTER, Supt., (1911)  
Nicholl's Hospital, Peterborough, Ont.
- FRANCIS A. DEVLIN, Supt., (1908)  
Municipal Hospital, Pittsburg, Pa.
- JAMES A. DEVORE, M.D., Supt., (1907)  
Devore Hospital and Sanatorium,  
Grand Rapids, Mich.
- MRS. SARAH M. DICKSON, Supt., (1910-11)  
Paragould Sanitarium, Paragould, Ark.
- W. C. DIXON, Supt., (1910-11)  
Vanderbilt University Hospital, Nashville, Tenn.
- MISS A. LOUISE DIETRICH, Supt., (1909)  
St. Mark's Maternity Hospital, El Paso, Tex.
- F. C. DIVER, M.D., Supt., (1909)  
Dawson Hospital, Dawson, New Mexico.
- W. J. DOBIE, M.D., Supt., (1908)  
King Edward Sanatorium, Weston, Ont.
- MISS H. E. DODGE, Supt., (1910-11)  
General Hospital, Greenwich, Conn.

- C. E. DONLAN, Supt., (1910-11)  
Long Island Hospital, Boston Harbour, Mass.
- WM. R. DORR, M.D., Supt., (1909)  
City and County Hospital, San Francisco, Cal.
- ~~R. S. DOUGLAS, Trustee, (1910)~~  
~~N. E. Deaconess Hospital, Brookline, Mass.~~
- J. B. DRAPER, Supt., (1908)  
University Hospital, Ann Harbor, Mich.
- CHAS. A. DREW, M.D., Supt., (1909)  
Worcester City Hospital, Worcester, Mass.
- EDWARD L. DREWRY, Trustee, (1910)  
General Hospital, Winnipeg, Canada.
- ~~MISS JULIA DUFFY, Asst. Supt., (1910-11)~~  
~~State Hospital, Central Islip, N.Y.~~
- F. G. DU BOSE, M.D., Supt., (1910)  
Du Bose Hospital, Selma, Ala.
- HOWARD L. DUMBLE, M.D., Supt., (1909)  
The Cottage Hospital, Hood River, Ore.
- MISS JEANETTE DUNCAN, Supt., (1910-11)  
Delaware Hospital, Wilmington, Del.
- MISS JESSIE M. DURISTINE, Supt., (1909)  
Clearfield Hospital, Clearfield, Pa.
- MISS VERA D. EATON, Supt., (1908)  
Lockport City Hospital, Lockport, N.Y.
- MISS MARY ECHELBERGER, Assistant Supt., (1908)  
Polk Hospital, Polk, Pa. (*Associate.*)
- REV. JOHANNES F. ECKHARDT, Supt., (1909)  
Queen's Hospital, Honolulu, H.I.
- MISS CLARA EDGE, Asst. Supt., (1910-11)  
Cottage State Hospital, Mercer, Pa.
- MISS M. B. EDWARDS, Supt., (1911)  
University Hospital, Kansas City, Mo.
- DAVID EISMAN, Trustee, (1910)  
Jewish Hospital, St. Louis, Mo.
- EUGENE B. ELDER, M.D., Supt., (1905)  
The Macon Hospitals, Macon, Ga.

- MRS. MARGARET ELDER, Assistant Supt., (1909)  
The Macon Hospitals, Macon, Ga. (*Associate.*)
- MISS FLORENCE D. ELDRIDGE, Supt., (1908)  
Western Maryland Hospital, Cumberland, Md.
- MISS NANCY P. ELLICOTT, Supt., (1909)  
Rockefeller Institute Hospital, New York City.
- FRANK M. ELLIOTT, Trustee, (1911)  
Evanston Hospital Association, Evanston, Ill.
- MISS BERTHA ELLIOTT, Supt., (1909)  
Provincial Hospital, Kentville, N.S.
- W. E. ELWELL, M.D., Supt., (1905)  
National Soldiers' Home, Togus, Me.
- CHAS. P. EMERSON, M.D., Supt., (1908)  
Indianapolis, Ind.
- N. W. EMERSON, M.D., Trustee, (1910-11)  
Emerson Hospital, Boston, Mass.
- ERNEST B. EMERSON, Supt., (1910)  
North Wilmington, Mass.
- ISAAC W. ENGLAND, Trustee, (1908)  
Passaic General Hospital, Passaic, N.J.
- WILLIAM EPPS, Secretary to Hosp., (1907)  
Royal Prince Alfred Hospital,  
Sydney, New South Wales.
- MISS ELEANOR G. EVANS, Supt., (1910-11)  
Jefferson Surgical Hospital, Roanoke, Va.
- OLIVER W. EVERETT, M.D., Supt., (1910)  
Lincoln Sanatorium, Lincoln, Neb.
- MISS ARVILLA E. EVERINGHAM, Supt., (1908)  
Rome Hospital, Rome, N.Y.
- MISS HANNAH J. EWIN, Supt., (1910-11)  
Free Hospital for Women, Brookline, Mass.
- MISS IDA R. FALCONER, Supt., (1908)  
Corry Hospital, Corry, Pa.
- MISS IRENE FALLON, (1904)  
Millburn, N.J.
- LUKE W. FARMER, Trustee, (1908)  
Somerville Hospital, 92 Thurston St., Somerville, Mass.

- DR. C. P. FARNSWORTH, Supt., (1910-11)  
Chamberlain Sanitarium, Chamberlain, S. D.
- A. D. FELL, Supt., (1910-11)  
St. Luke's Homeopathic Hospital,  
Philadelphia, Pa.
- C. IRVING FISHER, M.D., Supt., (1901)  
Presbyterian Hospital, New York City.
- J. F. FITZGERALD, M.D., Supt., (1905)  
King's County Hospital, Brooklyn, N.Y.
- J. W. FLAVELLE, Trustee, (1908)  
Toronto General Hospital, Toronto, Ont.
- MISS ELIZABETH G. FLAWS, Supt., (1908)  
Butterworth Hospital, Grand Rapids, Mich.
- MARTIN W. FLEMING, Supt., (1908)  
Children's Hospital, San Francisco, Cal.
- MARK L. FLEMING, Ass't Supt., (1910)  
Bellevue Hospital, New York City, N.Y.
- ELISHA H. FLINN, Trustee, (1908)  
The Grace Hospital,  
1220 Penobscot Bldg., Detroit, Mich.
- HOMER FOLKS, Trustee, (1910)  
Loeb Memorial Hospital, New York City, N.Y.
- MISS SOPHIA M. FOLSOM, Supt., (1908)  
Mt. Sinai Hospital, Cleveland, O.
- MISS LOUISE FORD, R.N., Supt., (1910-11)  
Children's Hospital, Pittsburg, Pa.
- MISS CHARLOTTE FORESTER, Supt., (1908)  
University Hospital, Kansas City, Mo.
- J. W. FOWLER, M.D., Ph.D., Supt., (1910)  
City Hospital, Louisville, Ky.
- LOUIS J. FRANK, Supt., (1907)  
Beth Israel Hospital, New York City.
- DR. H. P. FROST, (Supt., (1910-11)  
Boston State Hospital, Dorchester, Mass.
- J. L. FREELAND, M.D., Supt., (1907)  
Indianapolis City Hospital, Indianapolis, Ind.



- MISS E. M. FENSTAD, Supt., (1910)  
Woonsocket Hospital, Woonsocket, R.I.
- MISS M. N. GABLE, Supt., (1909)  
Chambersburg Hospital, Chambersburg, Pa.
- DR. JNO. GALLWAY, Trustee, (1910-11)  
St. Francis Hospital, San Francisco, Cal.
- A. GARDNER, Trustee, (1910)  
Queen's and Children's Hospital, Honolulu, H.I.
- MISS ANNA C. GARRETT, Supt., (1908)  
Frankford Hospital, Frankford, Philadelphia, Pa.
- MISS HELEN M. GARRETT, Supt., (1905)  
City Hospital, Amsterdam, N.Y.
- FRANK GAVIN, M.D., Supt., (1904)  
Church Home Hospital, Baltimore, Md.
- JOS. GEEFEN, Supt., (1910-11)  
Mt. Sinai Hospital, Philadelphia, Pa.
- DR. J. C. GEORGE, Supt., (1910-11)  
Miami Valley Hospital, Dayton, O.
- MISS L. A. GIBERSON, Supt., (1909)  
American Oncologic Hospital, Philadelphia, Pa.
- MRS. GERTRUDE GIBSON, Supt., (1903)  
Prospect Heights Hospital, Brooklyn, N.Y.
- CHAS. A. GILL, Supt., (1904)  
Germantown Hospital, Germantown, Pa.
- WM. H. GILBERT, M.D., Supt., (1909)  
Mary Jane Gilbert Memorial Hospital,  
Evansville, Ind.
- MISS NELLIE GILLETTE, Supt., (1910-11)  
J. W. Norton Memorial Hospital, Louisville, Ky.
- ANDREW C. GILLIS, M.D., Supt., (1909)  
Mercy Hospital, Baltimore, Md.
- EDWIN GLADMON, M.D., Supt., (1910)  
Southern Pines Sanatorium,  
Southern Pines, N.C.
- MISS MARY E. GLADWIN, Principal, (1905)  
Scranton Road Hospital School of Nursing,  
Cleveland, O.

- MISS E. M. GLOVER, Supt., (1910-11)  
Washington Hospital, Hagerstown, Md.
- J. H. GLEASON, M.D., Trustee, (1910-11)  
Beacon Hill Hospital, Manchester, N.H.
- C. C. GODDARD, M.D., Manager, (1909)  
Evergreen Place Hospital, Leavenworth, Kan.
- S. W. GODDARD, M.D., Supt., (1910-11)  
Goddard Hospital, Brockton, Mass.
- MRS. LOUE B. GODWIN, (1908)  
Boulevard Sanatorium, Detroit, Mich.
- MISS LOUISE GOLDER, Supt., (1909)  
Bethseda Hospital, Cincinnati, O.
- ~~S. S. GOLDWATER, M.D., Supt., (1904)  
Mt. Sinai Hospital, New York City.~~
- WALTER S. GOODALE, M.D., Supt., (1910)  
Ernest Wende Hospital, Buffalo, N.Y.
- MISS MINNIE GOODNOW, Supt., (1905)  
Bronson Hospital, Kalamazoo, Mich.
- MISS MARY M. GOODRICH, Asst. Supt., (1905)  
Lawrence Hospital, Bronxville, N.Y.
- DR. C. W. GOODWIN, Supt., (1910-11)  
St. John's Guild Seaside Hospital, New Dorp, N.Y.
- HAROLD C. GOODWIN, M.D., Supt., (1908)  
Albany Hospital, Albany, N.Y.
- ALICE A. GORMAN, Supt., (1908).  
Dorchester Centre, Mass.
- MISS BEATRICE M. GOSLING, Supt., (1911)  
Noble Hospital, Westfield, Mass.
- MISS DOROTHEA GOTHSON, Supt., (1910-11)  
Swedish Hospital, Brooklyn, N.Y.
- MISS MABEL GRAHAM, Asst. Supt., (1910-11)  
Christ Hospital, Jersey City, N.J.
- WILLARD T. GRAHAM, M.D., Supt., (1909)  
Methodist Episcopal Hospital, Indianapolis, Ind.
- MISS JANET GORDON GRANT, Supt., (1908)  
Moses Taylor Hospital, Scranton, Pa.

- EMIL GREENBURG, Asst. Supt., (1911)  
Beth Israel Hospital, New York City.
- MISS FAISON GRAY, Supt., (1910-11)  
Grace Hospital, Cleveland, O.
- F. D. GREENE, Sec'y  
Hospital Saturday and Sunday Ass'n, New York City.
- JEROME D. GREENE, Supt., (1910)  
Rockefeller Institute, New York City.
- MRS. JESSIE L. GREENE, Supt., (1909)  
Conemaugh Valley Memorial Hospital,  
Johnstown, Pa.
- MISS ELIZABETH A. GREENER, Supt., (1908)  
Hackley Hospital, Muskegon, Mich.
- MISS E. R. GREENE, Supt., (1910-11),  
Hospital for Incurables, Toronto, Canada.
- MISS M. H. GREENWOOD, Supt., 1910-11)  
Jewish Hospital, Avondale, Cincinnati, O.
- LEWIS T. GRIFFITH, M.D., Supt., (1908)  
New York Red Cross Hospital, New York City.
- CHAS. B. GRIMSHAW, Supt., (1907)  
Roosevelt Hospital, New York City.
- JOHN GUNN, Supt., (1906)  
Polyclinic Hospital, New York City.
- WM. A. GUTHRIE, M.D., Supt., (1909)  
Southern Kentucky Sanatorium, Franklin, Ky.
- CARRIE M. HALL, R.N., Supt., (1910)  
Margaret Pillsburg Hospital, Concord, N.H.
- MISS EVELYN H. HALL, Supt., (1907)  
Seattle General Hospital, Seattle, Wash.
- MISS WILHELMINA HAMILTON, Ass't Supt., (1909)  
Jackson City Hospital, Jackson, Mich. (*Associate*)
- MISS MARY C. HANNA, Supt., (1910)  
The Roosevelt Hospital, Philadelphia, Pa.
- IRVINE HARDY, M.D., Supt., (1910)  
Allegheny Heights Hospital, Davis, W. V.
- MISS BERTHA HART, Supt., (1910-11)  
Hart Private Hospital, Roxbury, Mass.

- WILLIAM H. HART, Pres., (1910)  
General Hospital, New Britain, Conn.
- MISS CLARA V. HARING, Supt., (1908)  
Allentown Hospital, Allentown, Pa.
- ARTHUR H. HARRINGTON, M.D., Supt., (1905)  
Rhode Island State Hospital for Insane,  
Providence, R.I.
- J. T. HARRINGTON, M.D., Supt., (1910-11)  
Vassar Bros. Hospital, Poughkeepsie, N.Y.
- DR. R. B. HARRIS, Trustee,  
Battle Creek Sanitarium, Battle Creek, Mich.
- MISS L. ELLEN HARRISON, Supt., (1910)  
Harriston Hospital, Chaunte, Kans.
- MARIE A. HARRISON, Supt., (1910-11)  
Overlook Hospital, Summit, N.J.
- MORRIS HARRISON, Supt., 1909)  
Muhlenburg Hospital, Plainfield, N.J.
- WM. H. HART, Trustee, (1910)  
New Britain General Hospital, New Britain, Conn.
- MISS HARRIET HARTY, Supt., (1907)  
St. Barnabas Hospital, Minneapolis, Minn.
- MISS GRACE P. HASKELL, Supt., (1909)  
Wentworth Hospital, Dover, N.H.
- ROBERT E. HASTINGS, Trustee, (1909)  
University of Pennsylvania Hospital,  
Philadelphia, Pa.
- HENRY B. HATHAWAY, Trustee, (1907)  
Rochester Homoeopathic Hospital,  
66 S. Washington St., Rochester, N.Y.
- PANSY A. HAVENS, Supt., (1910)  
Sibley Memorial Hospital, Washington, D.C.
- MR. E. P. HAWORTH, Supt., (1910-11)  
The Willows, Kansas City, Mo.
- MISS CATHERINE P. HAYDEN, Assistant Supt., (1908)  
St. Agnes Hospital, Raleigh, N.C. (*Associate*)
- MARY J. HAYS, M.D., Supt., (1908)  
Kane Summit Hospital, Kane, Pa.

- T. H. HEARD, Supt., (1905)  
Victoria Hospital, London, Ont.
- IRVING J. HECKMAN, M.D., Supt., (1910)  
Pasadena Hospital, Pasadena, Cal.
- BERNA M. HENDERSON, R.N., Supt., (1910)  
Children's Memorial Hospital, Chicago, Ill.
- ELLIOTT M. HENDERSON, Trustee, (1908)  
Passaic General Hospital,  
129 Lafayette Ave., Passaic, N.J.
- MISS S. HENRY, Supt., (1908)  
Newburgh Hospital, Newburg, N.Y.
- MILTON P. HERRMANN, Trustee, (1909)  
Mt. Sinai Hospital, New York City.
- MISS H. R. HEYWOOD, Trustee  
Haywood Memorial Hospital, Gardner, Mass.
- MISS M. EUGENIE HIBBARD, (1908)  
Departamento de Meneficencia, Havana, Cuba.
- MRS. E. J. A. HIGGINS, Supt., (1902)  
Boston Lying-in Hospital, Boston, Mass.
- J. F. HIGHSMITH, M.D., Supt., (1908)  
Highsmith Hospital, Fayetteville, N.C.
- MISS MAY Y. HILL, Supt., (1908)  
West Side Hospital, Scranton, Pa.
- MISS HELEN G. HILL, Supt., (1909)  
Children's Hospital, Buffalo, N.Y.
- FREDERICK G. HILLS, M.D., Supt., (1908)  
Eastern Maine Hospital for Insane, Bangor, Me.
- GRACE B. HINCHLEY, Supt., (1910)  
Choate Memorial Hospital, Woburn, Mass.
- A. F. N. HINDLEY, Assistant Supt., (1909)  
Eye, Ear and Throat Charity Hospital,  
Baltimore, Md. (*Associate*)
- MISS HELEN HINDMAN, Supt., (1910)  
Donaldson Hospital, Williamsport, Pa.
- L. P. HOBART, (1910-11)  
Member Society for Study and Prevention of  
Tuberculosis, San Francisco, Cal.



- MISS LOUISE HOERMAN, Assistant Supt., (1909)  
Bismarck Hospital and Deaconess' Home,  
Bismarck, N.D. (*Associate*)
- MISS ALMA HOGLE, Supt., (1905)  
Cleveland Homoeopathic Hospital, Cleveland, O.
- MISS ELIZ. HOGUE, Supt., (1910-11)  
Peninsula Hospital, Palo Alto, Cal.
- BRYAN HOLLINGS, Asst. Supt., (1910-11)  
Massachusetts General Hospital, Boston, Mass.
- G. ERNEST HOLMES, Trustee, (1910)  
Municipal Hospital, Saskatoon, Sask.
- MISS MAY S. HOLMES, Supt., (1908)  
Worcester Isolation Hospital, Worcester, Mass.
- MISS SUSAN HOLMES, Supt., (1908)  
Dr. Abbott's Hospital, Minneapolis, Minn.
- MISS E. M. HOOPER, R.N., Supt.,  
Christ Hospital, Jersey City, N.J.
- W. W. HOPPIN, Gov., (1908)  
New York Hospital,  
52 Williams St., New York City.
- MRS. MAUDE HORNER, Supt., (1909)  
Lyndhurst Hospital, College St., Toronto, Can.
- JOHN A. HORNSBY, M.D., Supt., (1907)  
Michael Reese Hospital, Chicago, Ill.
- E. H. HOWARD, M.D., Supt., (1909)  
Rochester State Hospital, Rochester, N.Y.
- MISS SADIE HOWARD, Supt., (1909)  
Vicksburg Sanatorium, Vicksburg, Miss.
- H. B. HOWARD, M.D., Supt., (1901)  
Peter Bent Brigham Hospital,  
697 Huntington Ave., Boston Mass.
- ELLEN E. HOWELL, M.D., (1910-11)  
Member Women's Southern Homeopathic  
Hospital Ass'n, Philadelphia, Pa.
- THOMAS HOWELL, M.D., Supt., (1902)  
New York Hospital, New York City.

- JOS. B. HOWLAND, M.D., Asst. Res. Physician, (1906)  
Mass. General Hospital, Boston, Mass. (*Associate*)
- J. L. HUDSON, Trustee, (1908)  
Harper Hospital, Detroit, Mich.
- MISS DOROTHY M. HUGO, Asst. Supt., (1908)  
Amsterdam City Hospital, Amsterdam, N.Y.  
(*Associate*)
- E. H. HUME, M.D., Supt., (1910)  
Yale Hospital, Chengsha, China.
- H. R. HUMMER, M.D., Supt., (1909)  
Asylum for Insane Indians, Canton, S.D.
- MISS ELLEN M. HUNT, Supt., (1909)  
Cottage State Hospital, Mercer, Pa.
- MISS JULIA HUNT, Supt., (1910-11)  
N.Y. Nursery and Children's Hospital,  
New York City.
- HENRY M. HURD, M.D., Supt., (1904)  
Johns Hopkins Hospital, Baltimore, Md.
- ARTHUR W. HURD, M.D., Supt., (1905)  
Buffalo State Hospital, Buffalo, N.Y.
- MISS LAURA B. ILLICK, Supt., (1905)  
Orange Memorial Hospital, Orange, N.J.
- MISS MARGARET INGLEHART, Trustee, (1908)  
Frances E. Willard Hospital,  
436 N. Clark St., Chicago, Ill.
- MISS ELLA C. INGWERSON, Supt., (1907)  
La Crosse Hospital, La Crosse, Wis.
- MRS. LOUISE H. ISHAM, Supt., (1910)  
Chicago Baptist College, Chicago, Ill.
- MISS CECILIA JACOBS, Supt., (1910-11)  
John Wells Memorial Hospital, New Brunswick, N.J.
- MISS MARY C. JACKSON, Supt., (1910-11)  
W. C. Graham Hospital, Keokuk, Ia.
- MISS MARY A. JAMESON, Supt., (1910-11)  
City Hospital, Springfield, O.
- MISS LUCIA L. JAQUITH, Supt., (1905)  
Memorial Hospital, Worcester, Mass.

- REV. T. P. JENZ, Supt., (1910)  
Evangelical Deaconess Hospital, St. Louis, Mo.
- BERTHA S. JOHNSON, R.N., Supt., (1910)  
Red Wing Hospital, Red Wing, Minn.
- IRVING P. JOHNSON, Trustee, (1909)  
St. Barnabas Hospital, Minneapolis, Minn.
- MISS IRENE M. JOHNSON, Supt., (1909)  
Memorial Hospital, Niagara Falls, N.Y.
- JAS. C. JOHNSTON, Supt., (1910-11)  
All Saints Hospital, McAlester, Okla.
- MISS KATHERINE JOHNSON, Asst. Supt., (1909)  
Homeopathic Hospital, Washington, D.C.  
(Associate)
- MISS MAUDE L. JOHNSTON, Supt., (1907)  
Rochester Homeopathic Hospital, Rochester, N.Y.
- ISRAEL C. JONES, M.D., Supt., (1904)  
Home for Incurables, Fordham, N.Y.
- J. L. JONES, M.D., Supt., (1908)  
Los Angeles Hospital, Los Angeles, Cal.
- MISS LEILA V. JONES, Supt., (1908)  
Roper Hospital, Charleston, S.C.
- MRS. R. MCK. JONES, Trustee, (1910)  
Children's Hospital, St. Louis, Mo.
- W. ALEXANDER JONES, M.D., Chr. Exec. Com. (1908)  
University Hospitals, Minneapolis, Minn.
- MARGARET M. JONES, M.D., Supt., (1909)  
Contagious Disease Hospital, Chicago, Ill.
- MISS NETTIE B. JORDAN, Supt., (1910)  
City Hospital, Aurora, Ill.
- MISS LUCY RIPLEY JOY, Supt., (1910)  
House of the Good Samaritan, Watertown, N.Y.
- JOS. C. JUDD, Trustee, (1910-11)  
Victoria Hospital, London, Canada.
- MISS LULU JUSTIS, (1910)  
Brokaw Hospital, Bloomington, Ill.
- REV. A. S. KAVANAGH, D.D., Supt., (1908)  
Methodist Episcopal Hospital, Brooklyn, N.Y.

- MISS MARION KEFFER, Asst. Supt., (1910-11)  
Hillcrest Hospital, Pittsfield, Mass.
- MRS. J. A. KEHELBECK, Trustee, (1908)  
The Jamaica Hospital,  
2195 Broadway, New York City.
- MISS MARY L. KEITH, Supt., (1905)  
Rochester General Hospital, Rochester, N.Y.
- MISS LYDIA H. KELLER, Supt., (1907)  
Cobb Hospital, St. Paul, Minn.
- J. H. KELLOGG, M.D., Supt., (1907)  
Battle Creek Sanatorium, Battle Creek, Mich.
- MISS ELEANOR KELLY, Supt., (1909)  
St. Luke's Hospital, Kansas City, Mo.
- MISS HONORA T. KELLY, Supt., (1910-11),  
Freemont Hospital, Freemont, Neb.
- GEO. B. KELSO, Supt., (1909)  
Kelso Sanatorium and Hospital, Bloomington, Ill.
- H. K. KENDALL, Architect,  
Newton Hospital, 92 Federal St., Boston, Mass.
- W. B. KENDALL, Supt., (1909)  
Cottage Sanatorium, Gravenhurst, Ont.
- WALLACE W. KENNEY, Supt., (1905)  
Victoria General Hospital, Halifax, N.S.
- WM. C. T. KERGIN, M.D., Supt., (1909)  
Port Simpson General Hospital,  
Port Simpson, B.C.
- H. B. KILDAHL, Supt., (1907)  
Norwegian Lutheran Hospital, Chicago, Ill.
- REV. G. A. KIENLE, Trustee, (1910-11)  
Emergency Hospital, Mansfield, O.
- MISS GRACE KINGSLEY, Asst. Supt., (1910-11)  
Memorial Hospital, Worcester, Mass.
- MISS MINERVA KINRICK, Supt., (1910-11)  
Dr. King's Hospital, Portland, Me.
- WALTER C. G. KIRCHNER, M.D., Supt., (1907)  
City Hospital, St. Louis, Mo.

- MRS. SARAH KNIGHT, Supt., (1908)  
Asbury M. E. Deaconess Hospital and Home,  
Minneapolis, Minn.
- MISS WILHELMINA KOBBELIER, Supt., (1908)  
Newark German Hospital, Newark, N.J.
- MISS ROSE KONOP, Supt., (1906)  
710 W. 12th St., Des Moines, Iowa.
- LOUIS KORTUM, Supt., (1907)  
German Hospital and Dispensary, New York City.
- JAS. S. KOSOWER, Supt., (1910-11)  
German Hospital, Cleveland, O.
- MISS ELIN K. KRAEMER, Supt., (1908)  
Frederick Ferris Thompson Hospital,  
Canandaigua, N.Y.
- ADOLF KUTTROFF, Trustee, (1908)  
German Hospital and Dispensary,  
128 Duane St., New York City
- MISS MINNIE LACKENBACK, Asst. Supt., (1909)  
Bellevue Hospital, San Francisco, Cal.  
(Associate)
- MISS LULU M. LACY, Supt., (1910-11)  
Emergency Hospital, Bonne Terre, Mo.
- MORTIMER LAMPSON, M.D., Supt., (1908)  
Jersey City Hospital, Jersey City., N.J.
- MISS MARY A. LAND, R.N., Supt., (1911)  
Mt. Vernon Hospital, Mt. Vernon, N.Y.
- MISS MAUD LANDIS, Supt., (1909)  
Levering Hospital, Hannibal, Mo.
- WALTER LATHROP, M.D., Supt., (1901)  
State Hospital, Hazelton, Pa.
- MRS. A. M. LAWSON, Supt., (1902)  
General Memorial Hospital, New York City.
- MISS MARIE A. LAWSON, Supt., (1903)  
City Hospital, Akron, O.
- REV. F. S. LEACH, Asst. Supt., (1911)  
St. Luke's Hospital, New York City



- MISS HARRIETT LECK, Asst. Supt., (1909)  
New General Hospital, Kansas City, Mo.  
(Associate)
- B. LEIDERSDORF, Ch. Ex. Com.,  
Columbia Hospital Ass'n, Milwaukee, Wis.
- E. F. LEIPER, Supt., (1911)  
P. E. Church Hospital, Philadelphia, Pa.
- MRS. BERTHA N. D. LESTER, Trustee, (1910)  
Saratoga Hospital, Saratoga Springs, N.Y.
- MISS JANE E. LESTER, Supt., (1910-11)  
United Hospital, Port Chester, N.Y.
- J. B. LEVISON, Trustee, (1910)  
Mt. Zion Hospital, San Francisco, Cal.
- MISS ADELAIDE M. LEWIS, Supt., (1907)  
Presbyterian Hospital, New Orleans, La.
- MRS. LOUISA H. LEWIS,  
Member Hospital Association, Belleville, Canada.
- SISTER M. LEWIS, Supt., (1907)  
Holy Cross Hospital, Salt Lake City, Utah.
- R. S. LIGIN, Trustee, (1909)  
Anderson County Hospital, Anderson, S.C.
- MISS LINA LIGHTBOURN, Supt., (1906)  
Hospital of the Good Shepherd, Syracuse, N.Y.
- E. O. LINDENMUTH, M.D., Supt., (1908)  
State College Hospital, Indianapolis, Ind.
- MISS MATILDA J. LINSKEY, Supt., (1907)  
Emergency Hospital, Mansfield, O.
- ALBERT W. LINDQUIST, Supt., (1910)  
Swedish Hospital, Kansas City, Mo.
- MISS MIRIAM LITTLE, Supt., (1907)  
National Homeopathic Hospital, Washington, D.C.
- MISS JULIA A. LITTLEFIELD, Supt., (1909)  
Schenectady Physicians' Hospital,  
Schenectady, N.Y.
- MISS ANNA C. LOCKERBY, Asst. Supt., (1910)  
Mary Hitchcock Memorial Hospital, Hanover, N.H.  
(Associate)

- HANAU W. LOEB, M.D.,  
Jewish Hospital, St. Louis, Mo.
- L. R. LOGAN, Supt., (1910-11)  
Hope Hospital, Ft. Wayne, Ind.
- W. K. LOUGHRIDGE, M.D., Supt., (1909)  
Dr. Loughridge's Private Hospital, Milford, Neb.
- MISS ELIZABETH LOUNSBERY, (1901)  
Ossing Hospital, Ossing-on-Hudson, N.Y.
- GEO. P. LUDLAM, Emeritus Supt., (1902)  
New York Hospital, New York City.
- L. W. LUSCHER, M.D., Supt., (1910)  
General Hospital, Kansas City, Mo.
- MISS FRANCES L. LURKINS, Supt., (1902)  
Laura Franklin Hospital for Children,  
New York City.
- WILLIAM L. LYALL, Trustee, (1908)  
Passaic General Hospital,  
349 Aycrigg Ave., Passaic, N.J.
- DAVID RUSSELL LYMAN, M.D., Supt., (1908)  
Gaylord Farm Sanatorium, Wallingford, Conn.
- MARTHA JEAN MACDONALD, Supt., (1910-11)  
Washington Hospital, Washington, N.C.
- A. S. McCAW, Trustee, (1910-11)  
Protestant Hospital, Sherbrooke, Canada.
- MISS MABEL McCALMONT, R.N.  
129 Columbia Heights, Brooklyn, N.Y.
- MISS L. McCALPIN, Asst. Supt.,  
Greely Hospital, Greely, O.
- DR. D. C. MALCOLM, Supt., (1910-11)  
General Hospital, St. John, Canada.
- SISTER MARIE, R.N., Supt.,  
Misericordia Hospital, New York City.
- MISS MARY MACGARRY, Supt., (1910-11)  
Charter Oak Private Hospital, Hartford, Conn.
- MRS. M. G. McCARTER, (1910-11)  
Member Com. for Reduction in Mortality,  
426 E. 26 St., New York City.

- J. B. MALONEY, M.D., Supt., (1910)  
    Louisa Maloney Hospital, Key West, Fla.
- MISS ELIZABETH McCLASKIE, Supt., (1906)  
    General Hospital, Port Huron, Mich.
- J. H. McCLELLAND, M.D., Trustee, (1908)  
    Homeopathic Hospital, Pittsburg, Pa.
- MISS ELSIE P. McCLOSKEY, M.D., Supt., (1908)  
    Brattleboro Memorial Hospital, Brattleboro, Vt.
- THEODORE MACCLURE, M.D., Supt., (1907)  
    Solway General Hospital, Detroit, Mich.
- MARGARET MACCLURE, (1910-11)  
    Member Visiting Nurses' Ass'n, St. Louis, Mo.
- JOHN H. MCCOLLOM, M.D., Supt., (1909)  
    Boston City Hospital, Boston, Mass.
- MISS KATHERINE McCONNELL, Supt., (1907)  
    Ashtabula General Hospital, Ashtabula, O.
- MISS SOPHIA G. McDONALD, Supt., (1909)  
    Moncton Hospital, Moncton, N.B.
- MISS LYDA MCFAYDEN, Supt., (1909)  
    Union Hospital, Terre Haute, Ind.
- SISTER MARY RAPHAEL MCGILL, Supt., (1907)  
    Mercy Hospital, Chicago, Ill.
- BERNARD McHUGH, Secretary, (1908)  
    Royal Arcanum Hospital Bed Fund Association,  
    76 Monroe St., Chicago, Ill.  
    (*Associate*)
- MISS A. COUSINS McKAY, Supt., (1909)  
    Alexandria Hospital, Alexandria, Va.
- MISS JESSIE McKENZIE, Supt., (1908)  
    California Woman's Hospital, San Francisco, Cal.
- MRS. F. G. McKIBBEN, M.D., Supt., (1909)  
    Keith Hospital, Topeka, Kan.
- M. V. McCUNE, Supt., (1910)  
    Shenandoah Valley Sanatorium,  
    Martinsburg, W. Va.
- STEWART McKEE, M.D., Supt., (1910)  
    Leavenworth Hospital, Leavenworth, Kansas.

- MRS. A. P. McLAUGHLIN, Supt., (1910)  
M. E. Hospital, Omaha, Neb.
- MISS FLORENCE N. MAILLENE, Supt., (1910)  
Canfield-White Hospital, Cleveland, O.
- W. O. MANN, M.D., Supt., (1902)  
Mass. Homeopathic Hospital, Boston, Mass.
- WALTER P. MANTON, M.D., Pres., (1908)  
Woman's Hospital, Detroit, Mich.
- MARIA E. MARTIN, Supt., (1910)  
Washington Heights Hospital,  
New York City, N.Y.
- C. D. MASSEY, Trustee, (1908)  
Toronto General Hospital,  
519 Jarvis Street, Toronto, Ont.
- SAMUEL MATHER, Trustee, (1910)  
Lakeside Hospital, Cleveland, O.
- MISS KATE MATHESON, Supt., (1908)  
Riverdale Isolation Hospital, Toronto, Ont.
- JAMES E. MATTHEWS, Supt., (1907)  
State Hospital, Scranton, Pa.
- S. G. MORBON MAULE, Trustee, (1909)  
Hahnemann Medical College and Hospital,  
Philadelphia, Pa.
- PHILIP C. MEANS, M.D., Asst. Supt., (1907)  
Soldiers' Home Hospital, Chelsea, Mass.  
(Associate.)
- MISS RACHEL A. METCALFE, Supt., (1907)  
Centre Maine General Hospital, Lewiston, Me.
- MISS GRACE E. MEYERS, Supt., (1910-11)  
Saginaw General Hospital, Saginaw, Mich.
- DR. CHAS. S. MILLET, Supt.,  
Millet Sanitarium, Brockton, Mass.
- MISS ANNIE G. MITCHELL, Supt., (1910-11)  
Isolation Hospital, Edmonton, Canada.
- MISS NELLIE MILLER, Supt., (1907)  
Ross Memorial Hospital, Lindsay, Ont.
- MISS LIVIA E. MILLER, Asst. Supt., (1910-11)  
Sibley Memorial Hospital, Washington, D.C.

- MISS MYRTLE E. MILLER, Asst. Supt., (1910-11)  
Brightlake Hospital, St. Johnsbury, Vt.
- JAS. A. MINNES, Trustee, (1910-11)  
General Hospital, Kingston, Canada.
- HARRY W. MITCHELL, M.D., Supt., (1909)  
Danvers State Hospital, Hathorne, Man.
- J. CARROLL MONMONIER, M.D., Supt., (1908)  
Dickeyville and Oella Dispensaries, Hillside, Mo.
- H. E. MONTGOMERY, Trustee, (1908)  
Buffalo Homeopathic Hospital, Buffalo, N.Y.
- JOHN C. MORFET, M.D., Commissioner, (1910)  
Robert Barnes Hospital, St. Louis, Mo.
- JOHN T. MOORE, M.D., Trustee, (1910)  
Texas Christian Sanatorium, Houston, Texas.
- MISS MARGARET M. MOORE, Supt., (1908)  
Jackson City Hospital, Jackson, Mich.
- ESTHER MORGAN, Supt., (1910)  
Dixie Hospital, Hampton, Va.
- JAMES D. MORGAN, M.D., Trustee, (1909)  
Central Dispensary and Emergency Hospital,  
919 Fifteenth St., Washington, D.C.
- MISS MABEL L. MORGAN, Supt.,  
Lansing City Hospital, Lansing, Mich.
- W. P. MORRILL, M.D., Supt., (1908)  
Sydenham Hospital, Baltimore, Md.
- C. C. MORRIS, Supt., (1910)  
Baptist Hospital, St. Louis, Mo.
- DR. L. B. MORRISON, Asst. Supt., (1910-11)  
Mary Fletcher Hospital, Burlington, Vt.
- R. J. MORRISON, M.D., Supt., (1911)  
Trustee, Williamsburg Hospital, Brooklyn, N.Y.
- MISS MARTHA G. E. MORTON, Supt., (1908)  
General and Marine Hospital, Collingwood, Ont.
- R. W. MORVILLE, JR., Trustee, (1908)  
Faulkner Hospital, Jamaica Plain, Boston, Mass.
- II. J. MOSS, M.D., Asst. Supt., (1910)  
Mt. Sinai Hospital, New York City. (*Associate.*)

- N. F. MOSSELL, M.D., Supt., (1910)  
Frederick Douglas Memorial Hospital,  
Philadelphia, Pa.
- JOS. W. MOTT, Steward, (1910)  
Jefferson Hospital, Philadelphia, Pa. (*Associate.*)
- F. E. MOULDER, Supt., (1907)  
Harper Hospital, Detroit, Mich.
- MISS KATHERINE A. MOYER, Supt., (1909)  
Pottstown Hospital, Pottstown, Pa.
- WALTER MUCKLOW, Director, (1908)  
St. Luke's Hospital,  
46 Mutual Life Bldg., Jacksonville, Fla.
- MISS MARGARET MUNN, Supt., (1908)  
N. Y. Infirmary for Women and Children,  
New York City.
- MISS A. C. MURRAY, Supt., (1910)  
Cushing Hospital, Leavenworth, Kansas.
- DR. T. J. MURRAY, Trustee, (1910-11)  
Murray Hospital, Butte, Mont.
- MISS J. E. NASH, Supt., (1910-11)  
Fordham Hospital, New York City.
- DR. WILLIS G. NEALLEY, Asst. Supt., (1911)  
New York Hospital, New York City.
- MISS MARY K. NELSON, Supt., (1909)  
P. E. Truesdale Hospital, Fall River, Mass.
- MISS GEORGIA M. NEVINS, Supt., (1909)  
Garfield Memorial Hospital, Washington, D.C.
- MISS JEANNE NEWINGTON, Supt., (1909)  
Latrobe Hospital, Latrobe, Pa.
- MRS. ADA R. NESBITT, R.N., Supt., (1910-11)  
American School of Osteopathy, Kirksville, Mo.
- MISS M. A. NEWTON, Supt., (1904)  
Sara Leigh Hospital, Norfolk, Va.
- JOHN H. NICHOLS, M.D., Supt., (1904)  
State Hospital, Tewkesbury, Mass.
- ESTES NICHOLS, M.D., Supt., (1909)  
Maine State Sanatorium, Hebron, Me.



- MISS MARY L. NIES, Supt., (1910)  
Frederick City Hospital, Frederick, Md.
- MISS ELIZABETH B. NIGHTINGALE, Asst. Supt., (1909)  
Wesson Maternity Hospital, Springfield, Mass.  
(Associate.)
- ALFRED I. NOBLE, M.D., Supt., (1907)  
Hospital for Insane, Kalamazoo, Mich.
- FRANK NORBURY, A.M., M.D., Supt., (1910)  
Kankakee State Hospital, Kankakee, Ill.
- RUPERT NORTON, M.D., Asst. Supt., (1907)  
Johns Hopkins Hospital, Baltimore, Md. (Associate.)
- EX. NORTON, Trustee, (1909)  
S. R. Smith Infirmary, Staten Island, N.Y.
- HENRY F. NOYES, Pres., Board of Trustees, (1907)  
Brooklyn Hospital, Brooklyn, N.Y.
- GUY F. NOYES, M.D., Supt., (1910)  
Parker Memorial Hospital, Columbia, Mo.
- MISS IDA NUDELL, Supt., (1908)  
White Plains Hospital, White Plains, N.Y.
- MISS IDA A. NUTTER, Supt., (1908)  
Franklin Hospital, Franklin, N.H.
- MISS MARTHA OAKS, Supt., (1910-11)  
St. Luke's Hospital, Davenport, Ia.
- REUBEN O'BRIEN, Supt., (1901)  
Manhattan Eye and Ear Hospital, New York City.
- MISS DELIA O'CONNELL, Supt., (1908)  
Rest Hospital, Minneapolis, Minn.
- GEORGE O'HANLON, Supt., (1910)  
Bellevue Hospital, New York City, N.Y.
- G. W. OLSON, Trustee, (1910)  
Swedish Hospital, Minneapolis, Minn.
- CLARENCE S. ORDWAY, M.D., Supt., (1910-11)  
East Side Hospital, Toledo, O.
- H. L. ORTH, M.D., Supt., (1909)  
Pennsylvania State Lunatic Hospital,  
Harrisburg. 11

- MISS MARY W. OSBORNE, Supt., (1907)  
Brooklyn Hospital, Brooklyn, N.Y.
- W. S. OVERTON, M.D., Supt., (1909)  
Moore-Overton Hospital, Binghamton, N.Y.
- G. W. OVERMEYER, Supt., (1910-11)  
Willaha Harbor Hospital, Raymond, Wash.
- MISS M. M. PABOO, Supt., (1910-11)  
Josephine Hospital, St. Louis, Mo.
- DR. O. F. PAGE, Supt., (1910)  
City Hospital, Sand Point, Idaho.
- HELEN B. PAGE, Supt., (1910)  
Memorial Orange Hospital, Orange, N.J.
- MISS S. C. PALMER, Assistant Supt., (1909)  
Asbury M. E. Deaconess Hospital and Home,  
Minneapolis, Minn. (*Associate.*)
- PAUL PAQUIN, M.D., Supt., (1909)  
Asheville-Biltmore Sanatorium, Asheville, N.C.
- J. H. S. PARKE, Supt., (1907)  
Montreal General Hospital, Montreal, Que.
- MISS ANNA CHANDLER PARKER, Supt., (1905)  
Hale Hospital, Haverhill, Mass.
- NELL F. PARRISH, Supt., (1910)  
City Hospital, East Liverpool, O.
- MISS MARION G. PARSONS, Asst. Supt., (1909)  
City and County Hospital, San Francisco, Cal.  
(*Associate.*)
- MISS ADAH H. PATTERSON, Supt., (1908)  
St. Luke's Hospital, St. Paul, Minn.
- MISS JEANETTE M. PAULUS, (1907)  
1003 Luttrell St., Knoxville, Tenn.
- MISS ESTHER PEARSON, Supt., (1909)  
Iowa Methodist Hospital, Des Moines, Iowa.
- T. S. PENDERGRASS, Supt., (1908)  
Saint Mark's Hospital, Salt Lake City, Utah.
- MISS RUTH PENTLAND, Supt., (1911)  
St. Luke's Hospital, Utica, N.Y.

- J. P. PERCIVAL, M.D., Supt., (1909)  
Norfolk Hospital for the Insane, Norfolk, Neb.
- MISS A. J. PERRY, Supt., (1910)  
Waterloo Presbyterian Hospital, Waterloo, Ia.
- MISS C. M. PERRY, R.N., Supt., (1910)  
Malden Hospital, Malden, Mass.
- MRS. M. O. PERRY, Supt., (1910-11)  
Nichol's Memorial Hospital, Battle Creek, Mich.
- JOHN M. PETERS, M.D., Supt., (1901)  
Rhode Island Hospital, Providence, R.I.
- MRS. ERNESTINE PETERSON, Supt., (1907)  
~~Red Cross Sanatorium, Rock Island, Ill.~~
- MISS ELIZABETH PETERSON, Supt., (1908)  
Swedish Hospital, Minneapolis, Minn.
- MISS CLARA D. PETTIT, Assistant Supt., (1904)  
Santa Fe Hospital, Los Angeles, Cal. (*Associate.*)
- MRS. EMMA PFATTEICHER, Trustee, (1910-11)  
Easton Hospital, Easton, Pa.
- ~~W. J. PICKARD, Asst. Supt.,~~  
~~Bellevue Hospital, New York City.~~
- R. M. PHELPS, M.D., Asst. Supt., (1909)  
Rochester State Hospital, Rochester, Minn.  
(*Associate*)
- W. T. PHY, M.D., Supt., (1910)  
Hot Lake Sanatorium, Oregon.
- W. B. PICKARD, D.D., Supt., (1910)  
St. Luke's Hospital, Cleveland, O.
- C. S. PITCHER, Steward, (1910-11)  
King's Park Sanatorium, King's Park, N.Y.
- CELESTINO PIVA, Pres., (1908)  
Italian Benevolent Institute and Hospital,  
167 W. Houston St., New York City.
- REV. D. R. PIVOTO, Supt., (1910)  
Baptist Sanatorium, Houston, Texas.
- F. C. PLATT, Trustee, (1908)  
New Britain General Hospital, New Britain, Conn.

- WALTER B. PLATT, M.D., Supt., (1908)  
Robert Garrett Hospital for Children,  
Baltimore, Md.
- H. M. POLLOCK, M.D., Supt., (1910-11)  
Norwich Hospital for Insane, Norwich, Conn.
- MISS N. M. PORTER, Supt., (1910-11)  
Samaritan Hospital, Sioux City, Ia.
- MISS VIRGINIA PORTER, Supt., (1909)  
Mercy Hospital, Kansas City, Mo.
- DR. M. R. PRATT, Supt., (1911),  
S. R. Smith Infirmary, Tompkinsonville, N.Y.
- HERMAN PRETZINGER, Trustee, (1908)  
Miami Valley Hospital, Dayton, O.
- GEO. M. PRICE, Trustee, (1908)  
Hospital of the Good Shepherd,  
412 S. Warren St., Syracuse, N.Y.
- MISS N. L. PUGH, Supt., (1910-11),  
Hospital Tarrytown-on-Hudson, N.Y.
- JOSEPH PURVIS, (1907)  
Madison General Hospital, Wis.
- MISS ANNIE E. RADFORD, Supt., (1910)  
Charlesgate Hospital, Cambridge, Mass.
- MISS ANNA H. RALSTON, Supt., (1910)  
Fern Hill Sanatorium, Edgewater, Col.
- A. J. RANNEY, M.D., Supt., (1905)  
Lakeside Hospital, Cleveland, O.
- J. M. RATCLIFF, M.D., Supt., (1909)  
Dayton Sanatorium, Dayton, O.
- SISTER M. FRANCES REGIS, Supt., (1910-11),  
St. Francis Hospital, Smith's Falls, Canada.
- JOHN REID, Supt., (1910)  
St. Margaret's Memorial Hospital, Pittsburg, Pa.
- MISS MARY H. RIDDLE, Supt., (1905)  
Newton Hospital, Newton, Mass.
- D. L. RICHARDSON, M.D., Supt., (1910)  
Providence City Hospital, Providence, R.I.

- ~~HENRY E. RICKETTS, M.D., Supt., (1911)~~  
~~Essex Co. Isolation Hospital, Belleville, N.J.~~
- B. D. RIDLON, M.D., Supt., (1907)  
National Home for Disabled Volunteer Soldiers,  
Togus, Me.
- MISS ANNA M. RINDLAUB, Supt., (1909)  
South Side Hospital, Pittsburg, Pa.
- GEO. L. RIVES, Trustee, (1909)  
New York Hospital, New York City.
- B. J. ROBERTS, Supt., (1909)  
Texas Baptist Memorial Hospital, Dallis, Tex.
- DONALD M. ROBERTSON, M.D., Supt., (1908)  
Co. of Carleton General Protestant Hospital,  
Ottawa, Ont.
- J. ROSS ROBERTSON, Pres. Board of Trustees, (1907)  
Hospital for Sick Children, Toronto, Ont.
- THOMAS K. ROBERTSON, Supt., (1907)  
N.Y. City Eye and Ear Infirmary,  
New York City.
- MARIE ROBERTSON, R.N., (1910)  
Warren Emergency Hospital, Warren, Pa.
- CHAS. R. ROBINS, M.D., (Member), (1910)  
Memorial Hospital, Richmond, Va.
- G. WILSE ROBINSON, M.D., Supt., (1909)  
Kansas City General Hospital, Kansas City, Mo.
- MISS MARGARET ROGERS, Supt., (1909)  
The Jewish Hospital, St. Louis, Mo.
- MISS R. C. ROGERS, R.N., Supt., (1910-11)  
General Hospital, Hoquani, Wash.
- SISTER M. ROSE, Supt., (1908)  
St. Elizabeth's Hospital, Boston, Mass.
- SISTER ROSE ALEXIUS, Supt., (1910)  
Glockner Hospital, Colorado Springs, Colo.
- DR. A. S. ROSENBLUTH, Supt., (1910-11)  
Loeb Convalescent Hospital, East View, N.Y.
- RENWICK R. ROSS, M.D., Supt., (1904)  
Buffalo General Hospital, Buffalo, N.Y.

- MRS. ANNA FLY ROTHROCK, Supt., (1909)  
The Union Hospital, Fall River, Mass.
- GEO. H. M. ROWE, M.D., (1901)  
Boston City Hospital, Boston, Mass.
- W. E. ROWLEY, M.D., Supt., (1907)  
General Hospital, St. John, N.B.
- MISS ALICE R. RUGGLES, Supt., (1910)  
Evanston Hospital, Evanston, Ill.
- A. L. RUSSELL, Trustee,  
R. M. and General Hospital, Port Arthur, Ont.
- MISS C. M. ROWAN, Supt., (1911)  
Elyria Memorial Hospital, Elyria, O.
- SISTER ST. JAMES, Superior, (1908)  
City Hospital, Ogdensburg, N.Y.
- SISTER OF ST. MARY, Supt.,  
St. Mary's Free Hospital for Children,  
New York City.
- MISS STELLA M. SAMPSON, Supt., (1910-11)  
St. Luke's Hospital, New Bedford, Mass.
- E. W. SAUNDERS, M.D., Supt., (1903)  
Bethesda Hospital, St. Louis, Mo.
- CEO. F. SAUER, Supt., (1909)  
Home of Rest for Consumptives,  
Bolton Road, New York City.
- REV. WM. SCHOENFIELD, (1910-11)  
Mem. Evangelical Lutheran Sanatorium,  
1294 Lexington Ave., New York City.
- L. A. SCHOLLENGER, M.D., Supt., (1910)  
Homeopathic Hospital, Reading, Penn.
- F. M. SCHULZ, M.D., Supt., (1908)  
Milwaukee County Hospital, Wauwatosa, Wis.
- MISS ANNA L. SCHULZE, Supt., (1908)  
German Hospital and Dispensary, New York City.
- MISS MARY SCHUMACKER, Supt., (1906)  
Sanatorium Hospital, Troy, N.Y.
- DAVID SCHWAB, Supt., (1908)  
The Hebrew Hospital, Baltimore, Md.



- ALICE M. SEABROOK, M.D., Supt., (1902)  
Women's Hospital, Philadelphia, Pa.
- RALPH B. SEEM, M.D., Supt., (1909)  
Jas. Walker Memorial Hospital, Wilmington, N.C.
- MISS M. T. SHACKELFORD, Supt., (1908)  
Pittman Hospital, Tarboro, N.C.
- NEWTON M. SHAFFER, M.D., Supt., (1909)  
N.Y. State Hospital for Crippled and Deformed  
Children, New York City.
- ~~MISS KATHERINE M. SHALTO, Assistant Supt., (1909)~~  
~~National Soldiers' Home, Tennessee. (Associate)~~
- C. T. SHARP, Asst. Supt., (1911)  
Kingston Ave. Hospital, Brooklyn, N.Y.
- MISS LUCY ASHLEY SHARP, Supt., (1910-11)  
New Rochelle Hospital, New Rochelle, N.Y.
- MISS FRANCES SHARPE, Supt., (1909)  
General Hospital, Woodstock, Ont.
- MISS CLARA B. SHARPE, Supt., (1910)  
Christian Hospital, St. Louis, Mo.
- HOBART P. SHATTUCK, M.D., Supt., (1909)  
Whitwell Hospital, Tuscon, Ariz.
- MISS MARY R. SHAVER, Supt., (1907)  
Good Samaritan Hospital, Lexington, Ky.
- RICHARD E. SHAW, M.D., Supt., (1901)  
Long Island College Hospital, Brooklyn, N.Y.
- MISS E. L. SHEA, Supt., (1910-11)  
Cottage State Hospital, Mercer, Pa.
- MOTHER SEBASTIAN SHEA, Supt., (1903)  
St. Mary's Hospital, Pueblo, Colo.
- C. C. SHELDON, M.D., Supt., (1904)  
Lynn Hospital, Lynn, Mass.
- MISS IDA F. SHEPARD, Supt., (1905)  
Mary Hitchcock Hospital, Hanover, N.H.
- MISS JESSIE M. SHERATON, Supt., (1905)  
Aberdeen Hospital, New Glasgow, N.S.
- MISS F. SHIEL, Supt., (1910-11)  
Peninsula Hospital, Salisbury, N.D.

- L. C. SHINGLE, Supt., (1909)  
Roosevelt Hospital, Berkeley, Cal.
- MISS H. A. SHIPLEY, R.N., Asst. Supt., (1910-11)  
Elm City Private Hospital, New Haven, Conn.
- ~~MISS STELLA SHIPLEY, Supt., (1909)~~  
~~Bartlesville Hospital, Bartlesville, Okla.~~
- FRANCES SHOUSE, Supt., (1910)  
Penn Valley Hospital, Kansas City, Mo.
- MISS F. D. SILVERMAN, Supt., (1910-11)  
Jewish Maternity Hospital, New York City.
- A. B. SIMONSON, M.D., Supt., (1909)  
Calumet & Hecla Hospital, Calumet, Mich.
- CHAS. E. SIMPSON, M.D., Supt., (1904)  
Lowell Hospital, Lowell, Mass.
- MISS S. A. SIMS, Supt., (1904)  
Youngstown Hospital, Youngstown, O.
- MISS A. B. SINSEBAUGH, Supt., (1910-11)  
Christian H. Buhl Hospital, Sharon, Pa.
- J. O. SKINNER, M.D., Supt., (1904)  
Columbia Hospital, Washington, D.C.
- CLARENCE E. SKINNER, M.D., (1909)  
Elm City Private Hospital, New Haven, Conn.
- MISS LAURA A. SLEE, Supt., (1900)  
Women's and Children's Hospital, Syracuse, N.Y.
- ~~E. B. SMITH, M.D., Trustee, (1910)~~  
~~Boulevard Sanatorium, Detroit, Mich.~~
- ~~F. R. SMITH, M.D., Supt., (1910)~~  
~~Winfield Hospital, Winfield, Kan.~~
- J. H. SMITH, Pres., (1908)  
St. Luke's Hospital, Cedar Rapids, Ia.
- JOHN M. SMITH, Supt., (1908)  
Grant Hospital, Columbus, O.
- J. WILLIAM SMITH, Trustee, (1908)  
Hospital of the Good Shepherd, Syracuse, N.Y.
- MISS L. I. SMITH, Supt., (1910-11)  
Martin's Ferry Hospital, Martin's Ferry, O.

- MISS MARY AGNES SMITH, Supt., (1908)  
Babies' Hospital, New York City.
- MISS NINA SMITH, Supt., (1910-11)  
St. Albans Hospital, St. Albans, Vt.
- WAYNE SMITH, M.D., Supt., (1908)  
Washington University Hospital and Dispensary,  
St. Louis, Mo.
- WINFORD H. SMITH, M.D., Supt., (1906)  
Johns Hopkins Hospital, Baltimore, Md.
- A. W. SMITH, M.D., Supt., (1909)  
Hartford Hospital, Hartford, Conn.
- H. M. SMITH, M.D., Supt., (1909)  
N. M. A. I. Hospital, East Las Vegas, New Mexico.
- MISS V. THERESA SMITH, Supt., (1909)  
California Woman's Hospital, San Francisco, Cal.
- HARRY E. SMITH, Supt., (1909)  
Baguio Division Hospital, Baguio, Benguet, P.I.
- MISS EMMA M. SMITH, Supt., (1909)  
Jordan Hospital, Plymouth, Mass.
- P. G. SMITH, M.D., Supt., (1909)  
Tuberculosis Hospital, Washington, D.C.
- W. B. SOUDER, Supt., (1910-11)  
W. Phila. Gen. Homeopathic Hospital,  
Philadelphia, Pa.
- MISS EDITH L. SOULE, Supt., (1910)  
Children's Hospital, Portland, Me.
- MISS H. SOUTHWORTH, R.N., Supt., (1910-11)  
Thrall Hospital, Middletown, N.Y.
- MISS MARIE SOWA, Supt., (1910-11)  
Easton Hospital, Easton, Pa.
- MRS. A. B. SPAULDING, Supt., (1910-11)  
Multnomah Co. Hospital, Portland, Ore.
- A. N. SPECTOR, Supt., (1910)  
Har Moriah Hospital, New York City.
- JAMES F. SPEER, Supt., (1909)  
Homeopathic Hospital, Pittsburg, Pa.

- W. H. SPILLER, M.D., Supt., (1908)  
New York Lying-in Hospital, New York City.
- SISTER INGEBORG SPOULAND, Supt., (1907)  
Norwegian Lutheran Deaconess' Hospital<sup>1</sup>  
Chicago, Ill.
- MISS JEWEL V. STAFFORD, Supt., (1909)  
Muskogee Hospital, Muskogee, Okla.
- MISS FLORENCE E. STANDISH, Supt., (1910)  
Col. Deaconess' Hospital, Colorado Springs, Col.
- A. J. STEELE, M.D., Asst. Supt., (1910)  
Missouri Baptist Sanatorium, St. Louis, Mo.
- REV. W. S. STEEN, Supt., (1902)  
Presbyterian Hospital, Philadelphia, Pa.
- MISS SOPHIA F. STEINHAUER, Supt., (1907)  
Speers Memorial Hospital, Dayton, Ky.
- ROSE K. STEMINETZ, Supt., (1910)  
Mary Day Nursery, Akron, Ohio.
- MISS MARY E. STELLING, Supt., (1908)  
Anderson County Hospital, Anderson, S.C.
- MISS WINIFRED L. STEVENS, Supt., (1909)  
The Clinton Hospital, Clinton, Mass.
- EDWARD F. STEVENS, Member Hosp. Com., (1909)  
N. E. Deaconess' Hospital, Boston, Mass.  
(Associate) 9 Park St., Boston.
- KATHERINE STEVENSON, Pres., (1910)  
West Philadelphia Hospital for Women,  
Philadelphia, Pa.
- D. A. STEWART, M.D., Trustee, (1909)  
Ninette Sanatorium, Winnipeg, Man.
- MISS MARY C. STEWART, Supt., (1908)  
Henrotin Memorial Hospital, Chicago, Ill.
- EWELL STOCKDALE, M.D., (1902)  
Sunny Rest Sanatorium, White Haven, Pa.
- J. EDWARD STOHLMANN, M.D., Supt., (1906)  
N.Y. Infant Asylum, New York City.
- LYDIA WEBSTER STOKES, M.D., Supt., (1909)  
Women's Southern Homeopathic Hospital,  
Philadelphia, Pa.

- MRS. H. D. STORCK, Supt., (1911)  
Buffalo Women's Hospital, Buffalo, N.Y.
- CHAS. STOVER, M.D., Trustee, (1909)  
Amsterdam City Hospital, Amsterdam, N.Y.
- C. EUGENE STRASSER, Supt., (1907)  
Jewish Hospital, Brooklyn, N.Y.
- JOS. V. STRAUB, Trustee, (1908)  
German Hospital,  
2310 Harrison St., Kansas City, Mo.
- J. R. STUART, M.D., Trustee, (1908)  
Houston Infirmiry Sanatorium, Houston, Tex.
- FREDERICK STURGIS, Trustee,  
Presbyterian Hospital, New York City.
- H. K. STURGIS, Trustee, (1910-11)  
New York Hospital, New York City.
- WM. B. SUMMERALL, M.D., Supt., (1909)  
Grady Memorial Hospital, Atlanta, Ga.
- H. T. SUMMERGILL, M.D., Supt., (1909)  
New Haven Hospital, New Haven, Conn.
- D. C. STRONG, Supt., (1910-11)  
San Bernardino Co. Hospital,  
San Bernardino, Cal.
- MISS ELIZ. SURBRAY, Supt., (1910-11)  
~~Warren City Hospital, Warren, Pa.~~
- MISS M. M. SUTHERLAND, Supt., (1910-11)  
Memorial Hospital, Pawtucket, R.I.
- ANNA M. SWEENEY, Supt., (1911)  
Franklin Co. Public Hospital, Greenfield, Mass.
- REV. PAUL F. SWETT, Supt., (1909)  
St. John's Hospital, Brooklyn, N.Y.
- FREDERICK SYMINGTON, Supt., (1904)  
William W. Backus Hospital, Norwich, Conn.
- CHAS. E. TALBOT, Supt., (1904)  
Newark City Hospital, Newark, N.J.
- WAIT TALCOTT, Secretary, (1908)  
Rockford Hospital Association, Rockford, Ill.

- MISS MARY J. TAYLOR, Supt., (1908)  
Homeopathic Hospital, Albany, N.Y.
- STELLA M. TAYLOR, M.D., Supt., (1903)  
New England Hospital for Women, Boston, Mass.
- MISS ELIZABETH C. TAYLOR, Supt., (1909)  
Episcopal Eye, Ear and Throat Hospital,  
Washington, D.C.
- MISS GRACE L. TAYLOR,  
Cottage Hospital, Good River, Ore.
- MISS JENNIE B. TESSER, Supt.  
Beacon Hill Hospital, Manchester, N.H.
- DANIEL D. TEST, Supt., (1900)  
Pennsylvania Hospital, Philadelphia, Pa.
- ELYSIAN THOMAS, Supt., (1910)  
Lakeside Hospital, Milwaukee, Wis.
- MISS MARY M. THOMPSON, Asst. Supt., (1909)  
F. F. Thompson Memorial Hospital,  
Canadaigua, N.Y. (*Associate*)
- CHAS. E. THOMPSON, M.D., Supt., (1909)  
Scranton Private Hospital, Scranton, Pa.
- CHAS. E. THOMPSON, M.D., Supt., (1909)  
State Colony for the Insane,  
Room 36, State House, Boston, Mass.
- W. C. THOMPSON, M.D., Supt., (1910)  
West Side Hospital, New York.
- W. V. S. THORNE, Trustee, (1910)  
Presbyterian Hospital, New York City, N.Y.
- GEO. TIMMINS, Trustee, (1908)  
Hospital of the Good Shepherd.  
1410 E. Genesee St., Syracuse, N.Y.
- J. G. TIMOLAT, Trustee, (1909)  
S. R. Smith Infirmary, Staten Island, N.Y.
- MISS ELIZ. A. TOOKE, Supt., (1910-11)  
Samaritan Hospital, Troy, N.Y.
- MISS H. G. TOLMIE, Supt., (1907)  
J. H. Stratford Hospital, Brantford, Ont.



- FREEMAN A. TOWER, Supt., (1910)  
Burbank Hospital, Fitchburg, Mass.
- RICHARD H. TOWNLEY, Supt., (1904)  
Lincoln Memorial Hospital, New York City.
- HOWARD TOWNSEND, Trustee, (1908)  
New York Hospital,  
32 Nassau St., New York City.
- L. G. TOWNSEND, Supt., (1907)  
Columbia Hospital, Columbia, Pa.
- MISS ANNIE M. TRIPPE, (1908)  
Portage La Prairie, Manitoba.
- MRS. C. M. TROUPE, Supt., (1910-11)  
Davis Hospital, Pine Bluff, Ark.
- HUGH H. TROUT, M.D.  
Jefferson Surgical Hospital, Roanoke, Va.
- PHILEMON E. TRUESDALE, M.D., (Trustee, (1909)  
P. E. Truesdale Hospital, Fall River, Mass.
- MISS M. TRUEHEART, Trustee, (1910)  
Sterling Hospital, Sterling, Kan.
- J. FRANK TRULL, M.D., Supt., (1908)  
Trull Hospital, Biddeford, Me.
- MISS ALICE I. TWITCHELL, Supt., (1905)  
Passavant Hospital, Jacksonville, Ill.
- MISS KATE L. B. TULLY, Supt., (1911)  
North Hudson Hospital, Werhauken, N.J.
- GEO. T. TUTTLE, Supt., (1909)  
McLean Hospital, Waverly, Mass.
- MRS. RUSSELL TYSON, Supt., (1908)  
Children's Memorial Hospital, Chicago, Ill.
- S. KATHERINE UBIL,  
Crozer Homeopathic Hospital, Chester, Pa.
- REV. M. UNGERLEIDER, Asst. Supt.  
Michael Reese Hospital, Chicago, Ill.
- MOTHER VALENCIA, Supt., (1908)  
St. Francis Hospital, Hartford, Conn.
- MISS C. P. VAN DER WATER, (1907)  
The Grace Hospital, Detroit, Mich. (*Associate*)

FRANK VAM KLEECK, Trustee, (1908)

Vassar Brothers' Hospital, Poughkeepsie, N.Y.

~~HENRY S. VAN DUZER~~, Trustee,

Presbyterian Hospital, New York City.

MISS ROSE Z. VAN VORT, (1907)

Norfolk Protestant Hospital, Richmond, Va.

MISS IDA B. VENNER, Supt., 1910-11)

Passavant Memorial Hospital, Jacksonville, Ill.

SIEGFRIED WACHSMANN, M.D., Med. Director, (1909)

Montefiore Home, New York City.

REV. M. WAHLSTROM, Supt., (1906)

Augustana Hospital, Chicago, Ill.

JOHN B. WALKER, M.D., Managing Director, (1908)

New York City Private Hospital Association,  
33 East 33rd St., New York City.

MISS MARGARET M. WALLACE, (1907)

171 Cherry St., Toledo Hospital, Toledo, Ohio.

MISS MARGARET A. WALLACE, Supt., (1909)

General Hospital, Passaic, N.J.

MRS. ELDORA H. WARD, Supt., (1904)

Jamaica Hospital, Jamaica, N.Y.

WM. A. WARFIELD, M.D., Supt., (1909)

Freedman's Hospital, Washington, D.C.

F. A. WASHBURN, M.D., Supt., (1904)

Mass. General Hospital, Boston, Mass.

MISS IDA WASHBURNE, Supt., (1908)

Eastern Maine General Hospital, Bangor, Me.

MRS. L. B. WATERS, Supt., (1907)

Passavant Memorial Hospital, Chicago, Ill.

~~MISS GRACE G. WATSON~~, Supt., (1908)

Children's Memorial Hospital, Chicago, Ill.

W. H. WEBER, (1899)

2401 Cedar St., Cleveland, O. (*Associate*)

MISS CARRIE WEBSTER, Supt., (1910-11)

All Saints' Hospital, Fort Worth, Texas.

~~H. E. WEBSTER~~, Supt., (1904)

Royal Victoria Hospital, Montreal, Que.

- OLIVE WEBSTER, Supt., (1910)  
Brewster Hospital, Jacksonville, Fla.
- MISS ELSIE WEICKERT, Supt., (1910-11)  
St. Mark's Hospital, New York City.
- ~~MISS MARGARET WEIGLE, Supt., (1910-11)  
Pullman Hospital, Chicago, Ill.~~
- MISS MARY J. WEIR, Supt., (1908)  
Braddock General Hospital, Braddock, Pa.
- G. A. WEIRICK, Asst. Supt., (1910-11)  
Dr. Broughton's Hospital, Rockford, Ill.
- A. W. WEISMANN, Supt., (1907)  
Hahnemann Hospital, New York City.
- MISS CORA J. WELKER, Supt., (1909)  
Knowlton Hospital, Columbia, S.C.
- JOHN WELLS, Supt., (1906)  
Latter Day Saints' Hospital, Salt Lake City, Utah.
- MISS ROSE C. WELLS, Supt., (1910-11)  
Eastern Long Island Hospital,  
Greenport, N.Y.
- R. S. WELLS, M.D., Supt., (1910)  
Northport Hospital, Northport, Wash.
- M. W. WENTWORTH, Manager, (1910)  
Battle Creek Sanatorium, Battle Creek, Mich.
- H. W. WERTZ, M.D., Supt., (1910)  
The Wertz Hospital, Montpelier, O.
- MISS ELEANOR WESTON, Supt., (1904)  
Northwestern Hospital, Minneapolis, Minn.
- MISS FLORENCE L. WETMORE, Supt., (1908)  
Flushing Hospital, Flushing, N.Y.
- ALEX. A. WHAMOND, Supt., (1910)  
Robert Burns Hospital, Chicago, Ill.
- LEONARD WHEELER, Trustee,  
Memorial Hospital, Worcester, Mass.
- ~~MISS MARY C. WHEELER, Supt., (1908)  
79 Dearborn, St., Chicago, Ill.~~
- J. T. WHITE, M.D., Supt., (1908)  
White Sanatorium and National Christian Hospital,  
Freeport, Ill.

- MISS REGINE WHITE, Supt., (1911)  
Johnston Emergency Hospital, Milwaukee, Wis.
- RICHARD J. WHITE, Trustee, (1907)  
Johns Hopkins Hospital, Baltimore, Md.
- GEO. F. WHITE, M.D., Supt., (1909)  
Channing Hospital, Providence, R.I.
- MISS LILLIAN L. WHITE, Supt., (1909)  
Samuel Merritt Hospital, Oakland, Cal.
- MILFORD W. WHITE, M.D., Supt., (1910)  
The White Hospital, Ravenna, O.
- JULIUS M. WILE, Trustee, (1909)  
Elgin State Hospital, Elgin, Ill.
- SIDNEY G. WILGUS, Supt., (1910)  
Rochester General Hospital, Rochester, N.Y.
- WILLIAM G. WILLCOX, Trustee, (1909)  
S. R. Smith Infirmary, Tompkinsville, N.Y.
- C. D. WILKINS, M.D., Supt., (1908)  
City Hospital, Wilkesbarre, Pa.
- DR. HOWARD WILLIAMS, Prop., (1910-11)  
Williams Sanatorium, Macon, Ga.
- MISS MAUDE WILLIAMS, Supt., (1910)  
Titusville, Pa.
- CLARENCE W. WILLIAMS, Chr. Hospital Com., (1908)  
New England Deaconess' Hospital,  
9 Park St., Boston, Mass.
- IRVING D. WILLIAMS, M.D., (1911)  
American Sanatorium Association,  
18 Gramercy Park, New York City.
- MISS ANNIE S. WILLIAMSON, Supt., (1908)  
Mary Washington Hospital, Fredericksburg, Va.
- JOHN M. WILLIAMSON, Pres., (1910-11)  
Trinity Hospital, San Francisco, Cal.
- DR. GORDON WILSON, Phy. in Chg.,  
Municipal Tuberculosis Hospital,  
Baltimore, Md.
- MISS MARGARET S. WILSON, Supt., (1905)  
Philadelphia Orthopedic Hospital, Philadelphia, Pa.

- ROBERT J. WILSON, Supt., (1907)  
Health Dept. Hospitals, Willard Parker Hospital,  
New York City.
- WAYNE McV. WILSON, M.D., Supt., (1909)  
New Mexico Cottage Hospital, Silver City, N. Mex.
- SIMON WINDKOS, M.D., Supt., (1909)  
Mt. Sinai Hospital, Philadelphia, Pa.
- W. S. WINTER, M.D., Supt., (1910)  
Lake View Hospital, Ft. Arthur, Texas.
- MISS AGNES M. WOOD, Supt., (1908)  
Middlesex County Hospital, Middletown, Conn.
- ANNA L. WOOD, Supt., (1910)  
Children's Hospital, St. Louis, Mo.
- E. A. WOOD, M.D., Supt., (1909)  
Maywood Hospital, Sedalia, Mo.
- DR. W. E. WOODBURY, Asst. Supt., (1911)  
Ionia State Hospital, Ionia, Mich.
- MISS EDITH WOOD, Supt., (1910-11)  
St. John's Riverside Hospital, Yonkers, N.Y.
- MISS GRACE F. WOODWARD, Supt., (1908)  
Baptist Memorial Hospital, Muskogee, Okla.
- MISS MARY WOODWORTH, Supt., (1910-11)  
Children's Hospital, Washington, D.C.
- J. D. WORKUM, Trustee, (1910-11)  
Jewish Hospital Ass'n, Avondale, Cincinnati, O.
- MISS M. WORTHINGTON, Supt., (1910-11)  
Home for Incurables, Newark, N.J.
- HORACE C. WRINCH, Supt., (1909)  
Hazelton Hospital, Hazelton, B.C.
- MISS M. E. WRAYTON, Supt., (1911)  
St. Joseph's Hospital, Glace Bay, N.S., Canada.
- WALTER E. WRIGHT, Asst. Supt. (1910)  
Post-Graduate Hospital, New York City, N.Y.
- MISS MARY L. WYCHE, Supt., (1908)  
Watts Hospital, Durham, N.C.
- JOHN A. WYETH, M.D., Trustee, (1911)  
N.Y. Polyclinic Hospital, New York City.

CHAS. H. YOUNG, M.D., Assistant Supt., (1908)

Presbyterian Hospital, New York City.

R. CLAUDE YOUNG, M.D., Supt., (1910)

Arkansas City, Kansas.

E. H. YOUNG, M.D., Asst. Supt.,

Rockwood Hospital for Insane, Kingston, Canada.

REBECCA S. YOUNG, Supt., (1910)

Methodist Episcopal Hospital, Philadelphia, Pa.

REV. R. A. YOUNG, Supt., (1911)

Otisville, N.Y.

S. J. YOUNG, Trustee, (1908)

Christian Hospital, Valparaiso, Ind.

THOMAS R. ZULICH, Supt., (1908)

Paterson General Hospital, Paterson, N.J.

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## MEMBERS

## LIST OF STATES

## ALABAMA (1)

F. G. DU BOSE, M.D., Supt., (1910)  
Du Bose Hospital, Selina, Ala.

## ARIZONA (1)

HOBART P. SHATTUCK, M.D., Supt., (1909)  
Whitwell Hospital, Tuscon, Ariz.

## ARKANSAS (2)

MRS. SARAH M. DICKSON, Supt., (1910-11)  
Paragould Sanitarium, Paragould, Ark.  
MRS. C. M. TROUPE, Supt., (1910-11)  
Davis Hospital, Pine Bluff, Ark.

## CALIFORNIA (21)

F. K. AINSWORTH, M.D., Exec. Head, (1908)  
So. Pacific R. R. Hospitals,  
810 James Flood Bldg., San Francisco, Cal.  
MISS LYDIA W. ANDERSON, Asst. Supt., (1908)  
Pasadena Hospital, Pasadena, Cal. (*Associate*).  
H. P. BARTON, M.D., Supt., (1908)  
Clara Barton Hospital, Los Angeles, Cal.  
EMELEE M. CHABOT, Member, (1910)  
Fabiola Hospital, Oakland, Cal. (*Associate*).  
MISS FLORA L. DANFORTH, Asst. Supt., (1909)  
Los Angeles Hospital, Los Angeles, Cal. (*Associate*).  
WM. R. DORR, M.D., Supt., (1909)  
City and County Hospital, San Francisco, Cal.  
DR. JNO. GALLWAY, Trustee, (1910-11)  
St. Francis Hospital, San Francisco, Cal.  
IRVING J. HECKMAN, M.D., Supt., (1910)  
Pasadena Hospital, Pasadena, Cal.

- L. P. HOBART, Esq., (1910-11)  
Member Society for Study and Prevention of  
Tuberculosis, San Francisco, Cal.
- MISS ELIZ. HOGUE, Supt., (1910-11)  
Peninsula Hospital, Palo Alto, Cal.
- J. L. JONES, M.D., Supt., (1908)  
Los Angeles Hospital, Los Angeles, Cal.
- MISS MINNIE LACKENBACK, Asst. Supt., (1909)  
Bellevue Hospital, San Francisco, Cal.  
(*Associate*)
- J. B. LEVISON, Trustee, (1910)  
Mt. Zion Hospital, San Francisco, Cal.
- MISS JENNIE MCKENZIE, Supt., (1908)  
California Woman's Hospital, San Francisco, Cal.
- MISS MARION G. PARSONS, Asst. Supt., (1909)  
City and County Hospital, San Francisco, Cal.  
(*Associate.*)
- MISS CLARA D. PETTIT, Assistant Supt., (1904)  
Santa Fe Hospital, Los Angeles, Cal. (*Associate.*)
- L. C. SHINGLE, Supt., (1909)  
Roosevelt Hospital, Berkeley, Cal.
- MISS V. THERESA SMITH, Supt., (1909)  
California Woman's Hospital, San Francisco, Cal.
- D. C. STRONG, Supt., (1910-11)  
San Bernardino Co. Hospital,  
San Bernardino, Cal.
- MISS LILLIAN L. WHITE, Supt., (1909)  
Samuel Merritt Hospital, Oakland, Cal.
- J. M. WILLIAMSON, Pres., (1910-11)  
Trinity Hospital, San Francisco, Cal.

## CANADA (50)

- DR. EDITH BEATTY, Supt., (1910)  
Grace Hospital, Toronto, Can.
- MISS CARRIE M. BOWMAN, Supt., (1907)  
Portage La Prairie General Hospital,  
Portage La Prairie, Man.

- H. A. BOYCE, M.D., Supt., (1908)  
General Hospital, Kingston, Ont.
- MISS LOUISE C. BRENT, Supt., (1906)  
Hospital for Sick Children, Toronto, Ont.
- J. N. E. BROWN, M.B., Supt., (1906)  
Toronto, Ont.
- MISS I. F. BULMER, Supt., (1910)  
Homeopathic Hospital, Montreal, Canada.
- AGNES E. BUSHFIELD, R.N.,  
806 Church St., Toronto, Can.
- MISS LILIAN CADE, Supt., (1910-11)  
R. M. and General Hospital, Port Arthur, Canada.
- MISS JANETTE E. CAMERON, Supt., (1907)  
St. Joseph's Hospital, Glace Bay, N.S., Canada.
- SISTER M. CLEMENT, Supt., (1910-11)  
St. Vincent de Paul Hospital, Brockville, Canada.
- MISS ANNIE A. CHESLEY, Supt., (1908)  
St. Luke's General Hospital, Ottawa, Ont.
- M. P. COCHRANE, Trustee, (1908)  
Western Hospital, Montreal, Que.
- J. M. COSGRAVE, Supt., (1905)  
Winnipeg Hospital, Winnipeg, Man.
- JOHN CROWE, Trustee, (1910-11)  
General Hospital, Guelph, Canada.
- MISS F. A. DE LA MATTER, Supt., (1911)  
Nicholl's Hospital, Peterborough, Ont.
- W. J. DOBBIE, M.D., Supt., (1908)  
King Edward Sanatorium, Weston, Ont.
- EDWARD L. DREWRY, Trustee, (1910)  
General Hospital, Winnipeg, Man.
- MISS BERTHA ELLIOTT, Supt., (1909)  
Provincial Hospital, Kentville, N.S.
- J. W. FLAVELLE, Trustee, (1908)  
Toronto General Hospital, Toronto, Ont.
- MISS E. R. GREENE, Supt., (1910-11),  
Hospital for Incurables, Toronto, Canada.

- T. H. HEARD, Supt., (1905)  
Victoria Hospital, London, Ont.
- G. ERNEST HOLMES, Trustee, (1910)  
Municipal Hospital, Saskatoon, Sask.
- MRS. MAUDE HORNER, Supt., (1909)  
Lyndhurst Hospital, Toronto, Ont.
- JOS. C. JUDD, Trustee, (1910-11)  
Victoria Hospital, London, Canada.
- W. B. KENDALL, Supt., (1909)  
Cottage Hospital, Gravenhurst, Ont.
- WALLACE W. KENNEY, Supt., (1905)  
Victoria General Hospital, Halifax, N.S.
- W. B. KENDALL, Supt., (1909)  
Port Simpson General Hospital,  
Port Simpson, B.C.
- MRS. LOUISA H. LEWIS,  
Member Hospital Association, Belleville, Ont.
- A. S. MCCAW, Trustee (1910-11)  
Protestant Hospital, Sherbrooke, Canada.
- DR. D. C. MALCOLM, Supt., (1910-11)  
General Hospital, St. John, N.B.
- MISS SOPHIA G. McDONALD, Supt., (1909)  
Moncton Hospital, Moncton, N.B.
- C. D. MASSEY, Trustee, (1908)  
Toronto General Hospital.
- MISS KATE MATHESON, Supt., (1908)  
Riverdale Isolation Hospital, Toronto, Ont.
- MISS ANNIE G. MITCHELL, Supt., (1910-11)  
Isolation Hospital, Edmonton, Canada.
- JAS. A. MINNES, Trustee, (1910-11)  
General Hospital, Kingston, Canada.
- MISS MARTHA G. E. MORTON, Supt., (1908)  
General and Marine Hospital, Collingwood, Ont.
- J. H. S. PARKE, Supt., (1907)  
Montreal General Hospital, Montreal, Que.
- SISTER M. FRANCES REGIS, Supt., (1910-11),  
St. Francis Hospital, Smith's Falls, Ont.

- DONALD M. ROBERTSON, M.D., Supt., (1908)  
Co. of Carleton General Protestant Hospital,  
Ottawa, Ont.
- J. ROSS ROBERTSON, Pres. Board of Trustees, (1907)  
Hospital for Sick Children, Toronto, Ont.
- A. L. RUSSELL, Trustee, (1909)  
R. M. and General Hospital, Port Arthur, Ont.
- MISS FRANCES SHARPE, Supt., (1909)  
General Hospital, Woodstock, Ont.
- MISS JESSIE M. SHERATON, Supt., (1905)  
Aberdeen Hospital, New Glasgow, N.S.
- D. A. STEWART, M.D., Trustee, (1909)  
Ninette Sanatorium, Winnipeg, Man.
- MISS H. G. TOLMIE, Supt., (1907)  
J. H. Stratford Hospital, Brantford, Ont.
- MISS ANNIE M. TRIPPE, (1908)  
Portage La Prairie, Manitoba.
- H. E. WEBSTER, Supt., (1904)  
Royal Victoria Hospital, Montreal, Que.
- HORACE C. WRINCH, Supt., (1909)  
Hazelton Hospital, Hazelton, B.C.
- MISS M. E. WRAYTON, Supt., (1911)  
St. Joseph's Hospital, Glace Bay, N.S., Canada.
- E. H. YOUNG, M.B., Asst. Supt.,  
Rockwood Hospital for Insane, Kingston, Canada.

## CHINA (1)

- EDW. H. HUME, M.D., Supt., (1911)  
Yale Hospital, Changsha, China.

## COLORADO (8)

- JAMES BLACK, Sec'y, (1909)  
Denver & Rio Grande R. R. Hospital Assn.,  
Denver, Colo. (*Associate*).
- M. COLLINS, M.D., Supt., (1903)  
National Jewish Hospital, Denver, Colo.
- R. W. CORWIN, M.D., Supt., (1910)  
Minnequa Hospital, Pueblo, Col.

- OCA CUSHMAN, Supt., (1910)  
Children's Hospital, Denver, Colo.  
SISTER ROSE ALEXIUS, Supt., (1910)  
Glockner Hospital, Colorado Springs, Colo.  
MISS ANNA H. RALSTON, Supt., (1910)  
Fern Hill Sanatorium, Edgewater, Col.  
MOTHER SEBASTIAN SHEA, Supt., (1903)  
St. Mary's Hospital, Pueblo, Colo.  
MISS FLORENCE E. STANDISH, Supt., (1910)  
Colorado Conference, Deaconess' Hospital,  
Colorado Springs, Colo.

## CONNECTICUT (19)

- MISS HARRIET J. ALLYN, Supt., (1911)  
Griffin Hospital, Derby, Conn.  
MRS. M. A. ANDREWS, Supt., (1902)  
Waterbury Hospital, Waterbury, Conn.  
MRS. JENNIE L. BASSETT, Supt., (1906)  
New Britain General Hospital, New Britain, Conn.  
MISS M. L. CUMMINS, Asst. Supt., (1911)  
Charter Oak Private Hospital, Hartford, Conn.  
MRS. S. W. CUTLER, Supt., (1906)  
Danbury Hospital, Danbury, Conn.  
MISS HANNAH DODGE, Supt., (1910-11)  
General Hospital, Greenwich, Conn.  
WILLIAM H. HART, Pres., (1910)  
New Britain General Hospital, New Britain, Ct.  
MISS MARION LITTLE, Supt., (1910)  
Grace Hospital, New Haven, Conn.  
DAVID RUSSELL LYMAN, M.D., Supt., (1908)  
Gaylord Farm Sanatorium, Wallingford, Conn.  
MISS MARY MACGARRY, Supt., (1910-11)  
Charter Oak Private Hospital, Hartford, Conn.  
F. G. PLATT, Trustee, (1908)  
New Britain General Hospital, New Britain, Conn.  
H. M. POLLOCK, M.D., Supt., (1910-11)  
Norwich Hospital for Insane, Norwich, Conn.



MISS H. A. SHIPLEY, R.N., Asst. Supt., (1910-11)  
Elm City Private Hospital, New Haven, Conn.

CLARENCE E. SKINNER, M.D., (1909)  
Elm City Private Hospital, New Haven, Conn.

A. W. SMITH, M.D., Supt., (1909)  
Hartford Hospital, Hartford, Conn.

H. T. SUMMERGILL, M.D., Supt., (1909)  
New Haven Hospital, New Haven, Conn.

FREDERICK SYMINGTON, Supt., (1904)  
William W. Backus Hospital, Norwich, Conn.

MOTHER VALENCIA, Supt., (1908)  
St. Francis Hospital, Hartford, Conn.

MISS AGNES M. WOOD, Supt., (1908)  
Middlesex County Hospital, Middletown, Conn.

#### CUBA (1)

MISS M. EUGENIE HIBBARD, (1908)  
Departamento de Meneficencia, Havana, Cuba.

#### DISTRICT OF COLUMBIA (10)

MRS. MADGE P. CARTER, Member Hospital Assn., (1909)  
Jennie Edmundson Memorial Hospital, Council Bluffs,  
Ia. Address: The Ventosa, 1st and B. Sts., Wash-  
ington, D.C. (*Associate.*)

MISS KATHERINE JOHNSON, Asst. Supt., (1909)  
Homeopathic Hospital, Washington, D.C.  
(*Associate*)

MISS LIVIA E. MILLER, Asst. Supt., (1910-11)  
Sibley Memorial Hospital, Washington, D.C.

JAMES D. MORGAN, M.D., Trustee, (1909)  
Central Dispensary and Emergency Hospital,  
Washington, D.C.

MISS GEORGIA M. NEVINS, Supt., (1909)  
Garfield Memorial Hospital, Washington, D.C.

J. O. SKINNER, M.D., Supt., (1904)  
Columbia Hospital, Washington, D.C.

P. G. SMITH, M.D., Supt., (1909)  
Tuberculosis Hospital, Washington, D.C.

MISS ELIZABETH C. TAYLOR, Supt., (1909)  
Episcopal Eye, Ear and Throat Hospital,  
Washington, D.C. (*Associate.*)

WM. W. WARFIELD, M.D., Supt., (1909)  
Freedman's Hospital, Washington, D.C.

MISS MARY WOODWORTH, Supt., (1910-11)  
Children's Hospital, Washington, D.C.

#### DELEWARE (1)

MISS JEANETTE DUNCAN, Supt., (1910-11)  
Deleware Hospital, Wilmington, Del.

#### FLORIDA (5)

MISS MARY ALBERTA BAKER, Supt., (1908)  
St. Luke's Hospital, Jacksonville, Fla.

MRS. ETHEL P. CLARK, Supt., (1908)  
DeSoto Sanatorium, Jacksonville, Fla.

J. B. MALONEY, M.D., Supt., (1910)  
Louisa Maloney Hospital, Key West, Fla.

WALTER MUCKLOW, Director, (1908)  
St. Luke's Hospital, Jacksonville, Fla.

OLIVE WEBSTER, Supt., (1910)  
Brewster Hospital, Jacksonville, Fla.

#### GEORGIA (8)

J. R. B. BRANCH, Supt., (1910)  
Macon Hospital, Macon, Ga.

GEORGE BROWN, Supt., (1910)  
Pine Ridge Hospital, Atlanta, Ga.

MISS MARY CAMPBELL, R.N., Supt., (1910-11)  
Williams' Private Sanitarium, Macon, Ga.

THOMAS J. CHARLTON, M.D., Supt., (1908)  
Savannah Hospital, Savannah, Ga.

EUGENE B. ELDER, M.D., Supt., (1905)  
The Macon Hospitals, Macon, Ga.

MRS. MARGARET ELDER, Assistant Supt., (1908)  
The Macon Hospitals, Macon, Ga. (*Associate.*)

- WM. B. SUMMERALL, M.D., Supt., (1909)  
Grady Hospital, Atlanta, Ga.  
DR. HOWARD WILLIAMS, Prop., (1910-11)  
Williams Sanatorium, Macon, Ga.

# HAWAIIAN ISLANDS (2)

- REV. JOHANNES F. ECKHARDT, Supt., (1909)  
Queen's Hospital, Honolulu, H.I.  
A. GARTNER, Trustee, (1910)  
Queen's and Children's Hospital, Honolulu, H.I.

# IDAHO (1)

- DR. O. F. PAGE, Supt., (1910)  
Sand Point, Idaho.

# ILLINOIS (53)

- MRS. SIDNEY APPELL, R.N., Supt., (1910)  
Ravenswood Hospital, Chicago, Ill.  
MISS ELIZABETH ASSELTINE, Supt., (1911)  
J. S. Ryburn Hospital, Ottawa, Ill.  
ASA BACON, Supt., (1906)  
Presbyterian Hospital, Chicago, Ill.  
MISS CHRISTINA J. BANKS, Asst. Supt., (1907)  
Wesley Hospital, Chicago, Ill. (*Associate.*)  
P. W. BEHRENS, Supt., (1909)  
German Hospital, Chicago, Ill.  
MISS SYLVIA BELL, Supt., (1908)  
South Chicago Hospital, Chicago, Ill.  
FRANK H. BOOTH, Supt., (1907)  
North West Side Hospital, Chicago, Ill.  
B. H. BREAKSTONE, Trustee, (1910-11)  
Maimoides Hospital, Chicago, Ill.  
MISS ANNA W. BRIDGES, Supt., (1910)  
Mary Thompson Hospital, Chicago, Ill.  
H. S. BURKHARDT, Pres., (1908)  
Central Free Dispensary of W. Chicago,  
311 Railway Exchange, Chicago, Ill.

- JAMES BURRY, Supt., (1910-11),  
Illinois Steel Co.'s Hospitals, Chicago, Ill.
- J. C. BURT, Supt., (1910-11)  
Hahnemann Hospital, Chicago, Ill.
- T. D. CATLIN, Trustee, (1910-11)  
J. S. Ryburn Hospital, Ottawa, Ill.
- MRS. J. T. CATLIN,  
Ottawa, Ill.
- MISS CHARLOTTE CHRISTIAN, Supt., (1910)  
Passavant Memorial Hospital, Chicago, Ill.
- MISS FRANCIS CRABTREE, (1909)  
Anna, Ill.
- LOUIS R. CURTIS, Supt., (1904)  
St. Luke's Hospital, Chicago, Ill.
- MISS AMELIA DAHLGREN, Supt., (1907)  
Englewood Hospital, Chicago, Ill.
- MISS ANNA LOUISE DAVIS, Trustee, (1908)  
Evanston Hospital, Evanston, Ill.
- FRANK M. ELLIOTT, Trustee, (1911)  
Evanston Hospital Association, Evanston, Ill.
- BERNA M. HENDERSON, R.N., Supt., (1910)  
Children's Memorial Hospital, Chicago, Ill.
- JOHN A. HORNSBY, M.D., Supt., (1907)  
Michael Reese Hospital, Chicago, Ill.
- MRS. LOUISE H. ISHAM, Supt., (1910)  
Chicago Baptist Hospital, Chicago, Ill.
- MISS MARGARET INGLEHART, Trustee, (1908)  
Frances E. Willard Hospital, Chicago, Ill.
- MARGARET M. JONES, M.D., Supt., (1909)  
Contagious Disease Hospital, Chicago, Ill.
- MISS NETTIE B. JORDAN, (1910)  
City Hospital, Aurora, Ill.
- MISS LULU JUSTIS, (1910)  
Brokaw Hospital, Bloomington, Ill.
- GEO. B. KELSO, Supt., (1909)  
Kelso Sanitorium and Hospital, Bloomington, Ill.

- H. B. KILDAHL, Supt., (1907) \*  
Norwegian Lutheran Hospital, Chicago, Ill.
- MISS ADELAIDE M. LEWIS, Supt., (1907)  
Ravenswood Hospital, Chicago, Ill.
- SISTER MARY RAPHAEL MCGILL, Supt., (1907)  
Mercy Hospital, Chicago, Ill.
- BERNARD MCHUGH, Secretary, (1908)  
Royal Arcanum Hospital Bed Fund Association,  
76 Monroe St., Chicago, Ill.  
(Associate)
- SIDNEY D. MEYERS, Supt., (1910),  
Elgin State Hospital, Elgin, Ill.
- FRANK NORBURY, A.M., M.D., Supt., (1910)  
Kankakee State Hospital, Kankakee, Ill.
- JOHN PURVIS, Supt., (1907)  
Madison General Hospital, Madison, Wis.
- MISS ALICE R. RUGGLES, Supt., (1910)  
Evanston Hospital, Evanston, Ill.
- SISTER INGEBORG SPOULAND, Supt., (1907)  
Norwegian Lutheran Deaconess' Hospital,  
Chicago, Ill.
- MISS ELLEN STEWART, Supt., (1907)  
Galesburg Hospital, Galesburg, Ill.
- MISS MARY C. STEWART, Supt., (1908)  
Henrotin Memorial Hospital, Chicago, Ill.
- WAIT TALCOTT, Secretary, (1908)  
Rockford Hospital Association, Rockford, Ill.
- MISS ALICE I. TWITCHELL, Supt., (1905)  
Passavant Hospital, Jacksonville, Ill.
- MRS. RUSSELL TYSON, Supt., (1908)  
Children's Memorial Hospital, Chicago, Ill.
- REV. M. UNGERLEIDER, Asst. Supt.  
Michael Riese Hospital, Chicago, Ill.
- MISS IDA B. VENNER, Supt., 1910-11)  
Passavant Memorial Hospital, Jacksonville, Ill.
- REV. M. WAHLSTROM, Supt., (1906)  
Augustana Hospital, Chicago, Ill.

- MRS. L. B. WATERS, Supt., (1907)  
Passavant Memorial Hospital, Chicago, Ill.
- MISS GRACE G. WATSON, Supt., (1908)  
Children's Memorial Hospital, Chicago, Ill.
- MISS MARGARET WEIGLE, Supt., (1910-11)  
Pullman Hospital, Chicago, Ill.
- G. A. WEIRICK, Asst. Supt., (1910-11)  
Dr. Broughton's Hospital, Rockford, Ill.
- DR. ALEX. A. WHAMOND, Supt., (1910)  
Robert Burns Hospital, Chicago, Ill.
- MISS MARY C. WHEELER, Supt., (1908)  
79 Dearborn, St., Chicago, Ill.
- J. T. WHITE, M.D., Supt., (1908)  
White Sanatorium and National Christian Hospital,  
Freeport, Ill.
- SIDNEY WILGUS, Supt., (1910-11)  
Elgin State Hospital, Elgin, Ill.

## INDIANA (6)

- MISS M. K. ADAMS, Supt., (1909)  
Hope Hospital, Fort Wayne, Ind.
- J. L. FREELAND, M.D., Supt., (1907)  
Indianapolis City Hospital, Indianapolis, Ind.
- WM. H. GILBERT, M.D., Supt., (1909)  
Mary Jane Gilbert Memorial Hospital,  
Evansville, Ind.
- WILLARD T. GRAHAM, M.D., Supt., (1909)  
Methodist Episcopal Hospital, Indianapolis, Ind.
- MISS LYDA MCFAYDEN, Supt., (1909)  
Union Hospital, Terre Haute, Ind.
- S. J. YOUNG, Trustee, (1908)  
Christian Hospital, Valparaiso, Ind.

## IOWA (8)

- MISS GRACE E. BAKER, Supt., (1907)  
St. Luke's Hospital, Cedar Rapids, Ia.
- MISS MARY C. JACKSON, Supt., (1910-11)  
W. C. Graham Hospital, Keokuk, Ia.



- MISS ROSE KONOP, Supt., (1906)  
710 W. 12th St., Des Moines, Iowa.  
ESTHER PEARSE, Supt., (1910)  
Iowa Methodist Hospital, Des Moines, Iowa.  
MISS ESTHER PEARSON, Supt., (1909)  
Iowa Methodist Hospital, Des Moines, Iowa.  
MISS AURILLA J. PERRY, Supt., (1910)  
Waterloo Presbyterian Hospital, Waterloo, Ia.  
MISS N. M. PORTER, Supt., (1910-11)  
Samaritan Hospital, Sioux City, Ia.  
J. H. SMITH, Pres., (1908)  
St. Luke's Hospital, Cedar Rapids, Ia.

## KANSAS (8)

- C. C. GODDARD, M.D., Manager, (1909)  
Evergreen Place Hospital, Leavenworth, Kan.  
MISS L. ELLÉN HARRISON, Supt., (1910)  
Harriston Hospital, Chaunte, Kans.  
STEWART MCKEE, M.D., Supt., (1910)  
Leavenworth Hospital, Leavenworth, Kansas.  
MRS. F. G. MCKIBBEN, M.D., Supt., (1909)  
Keith Hospital, Topeka, Kan.  
MISS M. TRUEHART, Trustee, (1910)  
Sterling Hospital, Sterling, Kan.  
MISS A. C. MURRAY, Supt., (1910)  
Cushing Hospital, Leavenworth, Kansas.  
F. R. SMITH, M.D., Supt., (1910)  
Winfield Hospital, Winfield, Kan.  
R. CLAUDE YOUNG, M.D., Supt., (1910)  
Arkansas City, Kansas.

## KENTUCKY (6)

- G. S. ADAMS, Louisville Hospital Commission, (1910)  
Louisville, Ky.  
J. W. FOWLER, M.D., Ph.D., Supt., (1910)  
City Hospital, Louisville, Ky.  
MISS NELLIE GILLETTE, Supt., (1910-11)  
J. W. Norton Memorial Hospital, Louisville, Ky.

- WM. A. GUTHRIE, M.D., Supt., (1909)  
Southern Kentucky Hospital, Franklin, Ky.  
MISS MARY R. SHAVER, Supt., (1909)  
Good Samaritan Hospital, Lexington, Ky.  
MISS SOPHIA F. STEINHAEUER, Supt., (1907)  
Speers Memorial Hospital, Dayton, Ky.

## LOUISIANA (2)

- GEO. S. BEL, M.D., Trustee, (1909)  
Charity Hospital, New Orleans, La.  
MISS ADELAIDE M. LEWIS, Supt., (1907)  
Presbyterian Hospital, New Orleans, La.

## MAINE (10)

- W. E. ELWELL, M.D., Supt., (1905)  
National Soldiers' Home, Togus, Me.  
DR. FREDERICK L. HILLS,  
Eastern Maine Hospital for Insane, Bangor, Me.  
MISS MINERVA KINRICK, Supt., (1910-11)  
Dr. King's Hospital, Portland, Me.  
MISS RACHEL A. METCALFE, Supt., (1907)  
Centre Maine General Hospital, Lewiston, Me.  
HARRY W. MITCHELL, M.D., Supt., (1909)  
Eastern Maine Asylum for the Insane, Bangor, Me.  
ESTES NICHOLS, M.D., Supt., (1909)  
Maine State Sanatorium, Hebron, Me.  
B. D. RIDLON, M.D., Supt., (1908)  
National Home for Disabled Volunteer Soldiers,  
Togus, Me.  
MISS EDITH L. SOULE, Supt., (1910)  
Children's Hospital, Portland, Me.  
J. FRANK TRULL, M.D., Supt., (1908)  
Trull Hospital, Biddeford, Me.  
MISS IDA WASHBURNE, Supt., (1908)  
Eastern Maine Asylum for the Insane, Bangor, Me.

## MARYLAND (18)

- CHAS. BAGLEY, JR., M.D., Med. Supt., (1909)  
Hebrew Hospital, Baltimore, Md.

- EDWARD N. BRUSH, M.D., Supt., (1909)  
Sheppard & Enoch Pratt Hospital,  
Howson, Station A, Baltimore, Md.
- J. CLEMENT CLARK, M.D., Supt., (1909)  
Springfield State Hospital, Sykesville, Md.
- MISS FLORENCE D. ELDRIDGE, Supt., (1908)  
Western Maryland Hospital, Cumberland, Md.
- FRANK GAVIN, M.D., Supt., (1904)  
Church Home Hospital, Baltimore, Md.
- ANDREW C. GILLIS, M.D., Supt., (1909)  
Mercy Hospital, Baltimore, Md.
- MISS E. M. GLOVER, Supt., (1910-11)  
Washington Hospital, Hagerstown, Md.
- A. F. N. HINDLEY, Assistant Supt., (1909)  
Eye, Ear and Throat Charity Hospital,  
Baltimore, Md. (*Associate*)
- HENRY M. HURD, M.D., Supt., (1904)  
Johns Hopkins Hospital, Baltimore, Md.
- J. CARROLL MONMONIER, M.D., Supt., (1908)  
Dickeyville and Oella Dispensaries, Hillsdale, Md.
- W. P. MORRILL, M.D., Supt., (1908)  
Sydenham Hospital, Baltimore, Md.
- MISS MARY L. NIES, Supt., (1910)  
Frederick City Hospital, Frederick, Md.
- RUPERT NORTON, M.D., Asst. Supt., (1907)  
Johns Hopkins Hospital, Baltimore, Md. (*Associate.*)
- WALTER B. PLATT, M.D., Supt., (1908)  
Robert Garrett Hospital for Children,  
Baltimore, Md.
- DAVID SCHWAB, Supt., (1908)  
The Hebrew Hospital, Baltimore, Md.
- RICHARD J. WHITE, Trustee, (1907)  
Johns Hopkins Hospital, Baltimore, Md.
- DR. GORDON WILSON, Phy. in Chg.,  
Municipal Tuberculosis Hospital,  
Baltimore, Md.

## MASSACHUSETTS (76)

- MISS EMMA A. ANDERSON, Supt., (1905)  
New England Baptist Hospital, Boston, Mass.
- MISS M. D. BARNABY, Supt., (1910)  
Haywood Memorial Hospital, Gardner, Mass.
- MISS GRACE B. BEATTIE, Supt., (1905)  
Brockton Hospital, Brockton, Mass.
- MISS JENNIE S. BERRY, R.N., Supt., (1911)  
Morton Hospital, Taunton, Mass.
- W. B. BIGELOW, Supt., (1910-11)  
Salem Hospital, Salem, Mass.
- H. M. BLACKSTONE, Supt., (1910)  
State Farm Hospital, State Farm, Mass.
- RICHARD P. BORDEN, Trustee, (1909)  
Union Hospital, Fall River, Mass.
- MISS SARA A. BOWEN, Supt., (1905)  
Lowell General Hospital, Lowell, Mass.
- MISS HILDA M. BOYD, Supt., (1910-11)  
Wesson Memorial Hospital, Springfield, Mass.
- W. C. BRAY, Trustee, (1910)  
Newton Hospital, Boston, Mass.
- G. LORING BRIGGS, Manager, (1909)  
Boston Floating Hospital, Boston, Mass.
- L. VERNON BRIGGS, M.D., Supt., (1909)  
Broad Oak Farm, Hanover, Mass.
- MISS WINIFRED H. BROOKS, Supt., (1909)  
Wesson Maternity Hospital, Springfield, Mass.
- LOUIS H. BURLINGTON, M.D., Asst. Supt., (1909)  
Massachusetts General Hospital, Boston, Mass.  
(Associate)
- MISS JENNIE E. CATTON, Supt., (1910-11)  
Springfield Hospital, Springfield, Mass.
- FARRAR COBB, M.D., Supt., (1905)  
Charitable Eye and Ear Hospital, Boston, Mass.
- EDMUND D. CODMAN, Trustee, (1909)  
Peter Bent Brigham Hospital, Boston, Mass.

- MISS LAURA E. COLEMAN, Supt., (1905)  
Faulkner Hospital, Jamaica Plain, Mass.
- MISS LOUISE M. COLEMAN, Supt., (1905)  
Hospital of the Good Samaritan, Boston, Mass.
- SIMON F. COX, Supt., (1910)  
Boston Consumptive Hospital, Boston, Mass.
- MISS EDITH I. COX, Supt., (1910-11)  
Faulkner Hospital, Jamaica Plains, Boston, Mass.
- C. E. DONLAN, Supt., (1910-11)  
Long Island Hospital, Boston Harbour, Mass.
- R. S. DOUGLAS, Trustee, (1910)  
N. E. Deaconess Hospital, Brookline, Mass.
- CHAS. A. DREW, M.D., Supt., (1909)  
Worcester City Hospital, Worcester, Mass.
- ERNEST B. EMERSON, Supt., (1910)  
North Wilmington, Mass.
- N. W. EMERSON, M.D., Trustee, (1910-11)  
Emerson Hospital, Boston, Mass.
- MISS HANNAH J. EWIN, Supt., (1910-11)  
Free Hospital for Women, Brookline, Mass.
- LUKE W. FARMER, Trustee, (1908)  
Somerville Hospital, Somerville, Mass.
- DR. H. P. FROST, (Supt., (1910-11)  
Boston State Hospital, Dorchester, Mass.
- S. W. GODDARD, M.D., Supt., (1910-11)  
Goddard Hospital, Brockton, Mass.
- ALICE A. GORMAN, Supt., (1908)  
Dorchester Centre, Mass.
- MISS BEATRICE M. GOSLING, Supt., (1911)  
Noble Hospital, Westfield, Mass.
- MISS BERTHA HART, Supt., (1910-11)  
Hart Private Hospital, Roxbury, Mass.
- MISS H. R. HEYWOOD, Trustee  
Haywood Memorial Hospital, Gardner, Mass.
- MRS. E. J. A. HIGGINS, Supt., (1902)  
Boston Lying-in Hospital, Boston, Mass.
- GRACE B. HINCHLEY, Supt., (1910)  
Choate Memorial Hospital, Woburn, Mass.

- BRYAN HOLLINGS, Asst. Supt., (1910-11)  
Massachusetts General Hospital, Boston, Mass.
- MISS MAY S. HOLMES, Supt., (1908)  
Worcester Isolation Hospital, Worcester, Mass.
- FRANK H. HOLT, M.D., Asst. Supt., (1909)  
Boston City Hospital, Worcester, Mass.
- H. B. HOWARD, M.D., Supt., (1901)  
Peter Bent Brigham Hospital, Boston, Mass.
- JOS. B. HOWLAND, M.D., Asst. Res. Physician, (1906)  
Mass. General Hospital, Boston, Mass.
- MISS LUCIA L. JAQUITH, Supt., (1905)  
Memorial Hospital, Worcester, Mass.
- MISS MARION KEFFER, Asst. Supt., (1910-11)  
Hillcrest Hospital, Pittsfield, Mass.
- H. K. KENDALL, Architect, (1911)  
Newton Hospital, 93 Federal St., Boston, Mass.
- MISS GRACE KINGSLEY, Asst. Supt., (1910-11)  
Memorial Hospital, Worcester, Mass.
- MISS DITA H. KINNEY, Supt.,  
Addison Gilbert Hospital, Gloucester, Mass.
- JOHN H. MCCOLLOM, M.D., Supt., (1909)  
Boston City Hospital, Boston, Mass.
- W. O. MANN, M.D., Supt., (1902)  
Mass. Homeopathic Hospital, Boston, Mass.
- PHILIP C. MEANS, M.D., Asst. Supt., (1907)  
Soldiers' Home Hospital, Chelsea, Mass.  
(Associate.)
- DR. CHAS. S. MILLET, Supt.,  
Millet Sanitarium, Brockton, Mass.
- R. W. MORVILLE, JR., Trustee, (1908)  
Faulkner Hospital, Jamaica Plain, Boston, Mass.
- MISS MARY K. NELSON, Supt., (1909)  
P. E. Truesdale Hospital, Fall River, Mass.
- JOHN H. NICHOLS, M.D., Supt., (1904)  
State Hospital, Tewkesbury, Mass.
- MISS ELIZABETH B. NIGHTINGALE, Asst. Supt., (1909)  
Wesson Maternity Hospital, Springfield, Mass.  
(Associate.)



- MISS ANNA CHANDLER PARKER, Supt., (1905)  
Hale Hospital, Haverhill, Mass.
- MISS ANNIE E. RADFORD, Supt., (1910)  
Charlesgate Hospital, Cambridge, Mass.
- MISS MARY H. RIDDLE, Supt., (1905)  
Newton Hospital, Newton, Mass.
- SISTER M. ROSE, Supt., (1908)  
St. Elizabeth's Hospital, Boston, Mass.
- MRS. ANNA ELY ROTHROCK, Supt., (1909)  
The Union Hospital, Fall River, Mass.
- GEO. H. M. ROWE, M.D., (1901)  
5 Ivy St., Boston, Mass.
- MISS STELLA M. SAMPSON, Supt., (1910-11)  
St. Luke's Hospital, New Bedford, Mass.
- C. C. SHELDON, M.D., Supt., (1904)  
Lynn Hospital, Lynn, Mass.
- CHAS. E. SIMPSON, M.D., Supt., (1904)  
Lowell Hospital, Lowell, Mass.
- MISS EMMA M. SMITH, Supt., (1909)  
Jordan Hospital, Plymouth, Mass.
- MISS WINIFRED L. STEVENS, Supt., (1909)  
The Clinton Hospital, Clinton, Mass.
- EDWARD F. STEVENS, Member Hosp. Com., (1909)  
N. E. Deaconess' Hospital, Boston, Mass.  
(Associate)
- ANNA M. SWEENEY, Supt., (1911)  
Franklin Co. Public Hospital, Greenfield, Mass.
- STELLA M. TAYLOR, M.D., Supt., (1903)  
New England Hospital for Women, Boston, Mass.
- CHAS. E. THOMPSON, M.D., Supt., (1909)  
State Colony for the Insane,  
Room 36, State House, Boston, Mass.
- FREEMAN A. TOWER, Supt., (1910)  
Burbank Hospital, Fitchburg, Mass.
- PHILEMON E. TRUESDALE, M.D., (Trustee, (1909)  
P. E. Truesdale Hospital, Fall River, Mass.
- GEO. T. TUTTLE, Supt., (1900)  
McLean Hospital, Waverly, Mass.

F. A. WASHBURN, M.D., Supt., (1904)  
Mass. General Hospital, Boston, Mass.

LEONARD WHEELER, Trustee, (1910-11)  
Memorial Hospital, Worcester, Mass.

CLARENCE W. WILLIAMS, Chr. Hospital Com., (1908)  
New England Deaconess' Hospital,  
9 Park St., Boston, Mass.

#### MICHIGAN (34)

MISS CHARLOTTE A. AIKENS, (1906)  
722 Sheridan Ave., Detroit, Mich.

MISS MARY J. ANDERSON, Trustee, (1911)  
Nichols Memorial Hospital, Battle Creek, Mich.

W. L. BABCOCK, M.D., Supt., (1906)  
The Grace Hospital, Detroit, Mich.

MISS IDA M. BARRETT, Supt., (1903)  
Union Benevolent Association Hospital,  
Grand Rapids, Mich.

JOHN W. BLODGETT, Trustee, (1907)  
Union Benevolent Association Hospital,  
Grand Rapids, Mich.

C. B. BURR, M.D., Supt., (1909)  
Oak Grove Sanatorium, Flint, Mich.

ALICE M. DEFOREST, M.D., (1909)  
Detroit, Mich.

JAMES A. DEVORE, M.D., Supt., (1907)  
DeVore Hospital and Sanatorium,  
Grand Rapids, Mich.

J. B. DRAPER, Supt., (1908)  
University Hospital, Ann Harbor, Mich.

MISS ELIZABETH G. FLAWS, Supt., (1908)  
Butterworth Hospital, Grand Rapids, Mich.

ELISHA H. FLINN, Trustee, (1908)  
The Grace Hospital, Detroit, Mich.

MRS. LOUE B. GODWIN, (1908)  
Boulevard Sanatorium, Detroit, Mich.

MISS MINNIE GOODNOW, Supt., (1905)  
Bronson Hospital, Kalamazoo, Mich.

- MISS ELIZABETH A. GREENER, Supt., (1908)  
Hackley Hospital, Muskegon, Mich.
- MISS WILHELMINA HAMILTON, Ass't Supt., (1907)  
Jackson City Hospital, Jackson, Mich. (*Associate*)
- ROWLAND B. HARRIS,  
Battle Creek Sanatorium, Battle Creek, Mich.
- J. L. HUDSON, Trustee, (1908)  
Harper Hospital, Detroit, Mich.
- J. H. KELLOGG, M.D., Supt., (1907)  
Battle Creek Sanatorium, Battle Creek, Mich.
- MISS ELIZABETH McCLASKIE, Supt., (1908)  
General Hospital, Port Huron, Mich.
- THEODORE McCLURE, M.D., Supt., (1907)  
Solway General Hospital, Detroit, Mich.
- WALTER P. MANTON, M.D., Pres., (1908)  
Woman's Hospital, Detroit, Mich.
- MISS GRACE E. MEYERS, Supt., (1910-11)  
Saginaw General Hospital, Saginaw, Mich.
- MISS MARGARET M. MOORE, Supt., (1908)  
Jackson City Hospital, Jackson, Mich.
- MISS MABEL MORGAN,  
City Hospital, Lansing, Mich.
- F. E. MOULDER, Supt., (1907)  
Harper Hospital, Detroit, Mich.
- ALFRED I. NOBLE, M.D., Supt., (1907)  
Hospital for Insane, Kalamazoo, Mich.
- REED PARKHURST, Asst. Supt., (1908)  
Muskegon County Hospital, Muskegon, Mich.  
(*Associate.*)
- MRS. MARY O. PERRY, Supt., (1910-11)  
Nichol's Memorial Hospital, Battle Creek, Mich.
- A. B. SIMONSON, M.D., Supt., (1909)  
Calumet & Hecla Hospital, Calumet, Mich.
- E. B. SMITH, M.D.,  
Boulevard Sanatorium, Detroit, Mich.
- MISS C. P. VAN DER WATER, (1907)  
The Grace Hospital, Detroit, Mich. (*Associate*)

- M. W. WENTWORTH, Business Manager, (1910)  
Battle Creek Sanatorium, Battle Creek, Mich.  
DR. W. E. WOODBURY, Asst. Supt., (1911)  
Ionia State Hospital, Ionia, Mich.

## MINNESOTA (18)

- A. B. ANCKER, M.D., Supt., (1902)  
City and County Hospital, St. Paul, Minn.  
RICHARD O. BEARD, M.D., Sec'y, (1909)  
University of Minnesota Hospitals  
Minneapolis, Minn.  
MISS EVA M. BRATTON, Supt., (1910-11)  
G. B. Wright Hospital, Fergus Falls, Minn.  
HERBERT O. COLLINS, M.D., Supt., (1909)  
City Hospital, Minneapolis, Minn.  
DANIEL C. DARROW, M.D., Supt., (1909)  
Moorhead Hospital, Moorhead, Minn.  
MISS HARRIET HARTY, Supt., (1907)  
St. Barnabas Hospital, Minneapolis, Minn.  
MISS SUSAN HOLMES, Supt., (1908)  
Dr. Abbott's Hospital, Minneapolis, Minn.  
IRVING P. JOHNSON, Trustee, (1909)  
St. Barnabas Hospital, Minneapolis, Minn.  
W. ALEXANDER JONES, M.D., Chr. Exec. Com. (1908)  
University Hospitals, Minneapolis, Minn.  
MISS LYDA KELLER, Supt., (1907)  
Cobb Hospital, St. Paul, Minn.  
MRS. SARAH KNIGHT, Supt., (1909)  
Asbury M. E. Deaconess Hospital and Home,  
Minneapolis, Minn.  
MISS DELIA O'CONNELL, Supt., (1908)  
Rest Hospital, Minneapolis, Minn.  
G. W. OLSON, Trustee, (1910)  
Swedish Hospital, Minneapolis, Minn.  
MISS S. C. PALMER, Assistant Supt., (1909)  
Asbury M. E. Deaconess Hospital and Home,  
Minneapolis, Minn. (*Associate.*)

- MISS ADAH H. PATTERSON, Supt., (1908)  
St. Luke's Hospital, St. Paul, Minn.
- MISS ELIZABETH PETERSON, Supt., (1908)  
Swedish Hospital, Minneapolis, Minn.
- R. M. PHELPS, M.D., Asst. Supt., (1909)  
Rochester State Hospital, Rochester, Minn.  
(Associate)
- MISS ELEANOR WESTON, Supt., (1904)  
Northwestern Hospital, Minneapolis, Minn.

## MISSISSIPPI (3)

- C. T. CHAMBERLAIN, M.D., Supt., (1910-11)  
Chamberlain Sanitarium, Natchez, Miss.
- MISS SADIE HOWARD, Supt., (1909)  
Vicksburg Sanatorium, Vicksburg, Miss.
- MISS CATHERINE E. MORGAN, Supt., (1908)  
So. Mississippi Infirmary, Hattiesburg, Miss.

## MISSOURI (38)

- J. M. BASKETT, M.D., Trustee, (1910)  
Levering Hospital, Hannibal, Mo.
- J. W. AMERMAN, M.D., Supt., (1911)  
Nevada Medical and Surgical Sanitarium, Nevada, Mo.
- CHAS. E. BAUR, Supt., (1910)  
City Hospital, St. Louis, Mo.
- J. H. CADWALLER, M.D., Supt., (1908)  
Missouri Baptist Sanatorium, St. Louis, Mo.
- MISS ANNIE M. CASEY, Supt., (1907)  
German Hospital, Kansas City, Mo.
- MRS. MARY J. CHAMBERS, Supt., (1908)  
St. Luke's Hospital, St. Louis, Mo.
- DR. C. B. CLAPP, M.D., Supt., (1910-11)  
R. C. and Wabash Employees Hospital,  
Moberley, Mo.
- MISS M. B. EDWARDS, Supt., (1911)  
University Hospital, Kansas City, Mo.
- DAVID EISMAN, Trustee, (1910)  
Jewish Hospital, St. Louis, Mo.

- MISS CHARLOTTE FORESTER, Supt., (1909)  
University Hospital, Kansas City, Mo.
- MR. E. P. HAWORTH, Supt., (1910-11)  
The Willows, Kansas City, Mo.
- REV. T. P. JENZ, Supt., (1910)  
Evangelical Deaconess Hospital, St. Louis, Mo.
- MRS. R. McK. JONES, Trustee, (1910)  
Children's Hospital, St. Louis, Mo.
- MISS ELEANOR KELLY, Supt., (1909)  
St. Luke's Hospital, Kansas City, Mo.
- WALTER C. G. KIRCHNER, M.D., Supt., (1907)  
City Hospital, St. Louis, Mo.
- MISS LULU M. LACY, Supt., (1910-11)  
Emergency Hospital, Bonne Terre, Mo.
- MISS MAUD LANDIS, Supt., (1909)  
Levering Hospital, Hannibal, Mo.
- MISS HARRIETT LECK, Asst. Supt., (1909)  
New General Hospital, Kansas City, Mo.  
(Associate)
- ALBERT W. LINDQUIST, Supt., (1910)  
Swedish Hospital, Kansas City, Mo.
- HANAU W. LOEB, M.D., Member, (1910)  
Jewish Hospital, St. Louis, Mo.
- L. W. LUSCHER, M.D.,  
General Hospital, Kansas City, Mo.
- MARGARET M. McCLURE,  
Visiting Nurses' Ass'n, St. Louis, Mo.
- JOHN C. MORFIT, M.D., Commissioner, (1910)  
Robert Barnes Hospital, St. Louis, Mo.
- MRS. ADA R. NESBITT, R.N., Supt., (1910-11)  
American School of Osteopathy, Kirksville, Mo.
- GUY F. NOYES, M.D., Supt., (1910)  
Parker Memorial Hospital, Columbia, Mo.
- C. C. MORRIS, Supt., (1910)  
Baptist Hospital, St. Louis, Mo.
- MISS M. M. PABOO, Supt., (1910-11)  
Josephine Hospital, St. Louis, Mo.



- MISS VIRGINIA PORTER, Supt., (1909)  
Mercy Hospital, Kansas City, Mo.
- G. WILSE ROBINSON, M.D., Supt., (1909)  
Kansas City General Hospital, Kansas City, Mo.
- MISS MARGARET ROGERS, Supt., (1909)  
The Jewish Hospital, St. Louis, Mo.
- E. W. SAUNDERS, M.D., Supt., (1903)  
Bethesda Hospital, St. Louis, Mo.
- MISS CLARA B. SHARPE, Supt., (1910)  
Christian Hospital, St. Louis, Mo.
- MISS FRANCES SHOUSE, Supt., (1910)  
Penn Valley Hospital, Kansas City, Mo.
- WAYNE SMITH, M.D., Supt., (1908)  
Washington University Hospital and Dispensary,  
St. Louis, Mo.
- A. J. STEELE, M.D., Asst. Supt., (1910)  
Missouri Baptist Sanatorium, St. Louis, Mo.  
(Associate.)
- JOS. V. STRAUB, Trustee, (1908)  
German Hospital, Kansas City, Mo.
- ANNA L. WOOD, Supt., (1910)  
Children's Hospital, St. Louis, Mo.
- E. A. WOOD, M.D., Supt., (1909)  
Maywood Hospital, Sedalia, Mo.

## MONTANA (2)

- MISS DELLA H. FOLGER, R.N., Supt., (1908)  
Murray Hill Hospital, Butte, Mont.
- MISS HANNA DEWEES, Supt., (1910-11)  
St. Peter's Hospital, Helena, Mont.

## NEBRASKA (7)

- BENJ. F. BAILEY, M.D., Supt., (1909)  
Benj. F. Bailey Sanatorium, Lincoln, Neb.
- M. W. BAXTER, M.D., Supt., (1909)  
Nebraska State Hospital, Ingleside, Neb.
- OLIVER W. EVERETT, M.D., Supt., (1910)  
Lincoln Sanatorium, Lincoln, Neb.

- MISS HONORA KELLY, Supt., (1910-11)  
Freemont Hospital, Freemont, Neb.  
W. K. LOUGHRIDGE, M.D., Supt., (1909)  
Dr. Loughridge's Private Hospital, Milford, Neb.  
MRS. A. P. McLAUGHLIN, Supt., (1910)  
M. E. Hospital, Omaha, Neb.  
J. P. PERCIVAL, M.D., Supt., (1909)  
Norfolk Hospital for the Insane, Norfolk, Neb.

## NEW HAMPSHIRE (7)

- J. H. GLEASON, M.D., Trustee, (1910-11)  
Beacon Hill Hospital, Manchester, N.H.  
CARRIE M. HALL, R.N., Supt., (1910)  
Margaret Pillsburg Hospital, Concord, N.H.  
MISS GRACE P. HASKELL, Supt., (1909)  
Wentworth Hospital, Dover, N.H.  
MISS ANNA C. LOCKERBY, Asst. Supt., (907)  
Mary Hitchcock Memorial Hospital, Hanover, N.H.  
(Associate)  
MISS IDA A. NUTTER, Supt., (1908)  
Franklin Hospital, Franklin, N.H.  
MISS IDA F. SHEPARD, Supt., (1905)  
Mary Hitchcock Hospital, Hanover, N.H.  
MISS J. B. TESSER, Supt., (1910-11)  
Beacon Hill Hospital, Manchester, N.H.

## NEW JERSEY (22)

- GEO. BAILEY, JR., Supt., (1901)  
The Cooper Hospital, Camden, N.J.  
S. J. BARNES, Asst. Supt., (1910-11)  
Orange Memorial Hospital, Orange, N.J.  
HENRY A. COTTON, M.D., Supt., (1909)  
New Jersey State Hospital, Trenton, N.J.  
ISAAC W. ENGLAND, Trustee, (1908)  
Passaic General Hospital, Passaic, N.J.  
MISS IRENE FALLON, (1904)  
Millburn, N.J.

- MISS MABEL GRAHAM, Asst. Supt., (1910-11)  
Christ Hospital, Jersey City, N.J.
- MISS M. A. HARRISON, Supt., (1910-11)  
Overlook Hospital, Summit, N.J.
- MORRIS HARRISON, Supt., 1909)  
Muhlenburg Hospital, Plainfield, N.J.
- ELLIOTT M. HENDERSON, Trustee, (1908)  
Passaic General Hospital, Passaic, N.J.
- MISS E. M. HOOPER, R.N., Supt., (Apr. 1911)  
Christ Hospital, Jersey City, N.J.
- MISS LAURA B. ILLICK, Supt., (1909)  
Orange Memorial Hospital, Orange, N.J.
- MISS CECILIA JACOBS, Supt., (1910-11)  
John Wells Memorial Hospital, New Brunswick, N.J.
- MISS WILHELMINA KOBBLIER, Supt., (1908)  
German Hospital, Newark, N.J.
- MORTIMER LAMPSON, M.D., Supt., (1908)  
Passaic General Hospital, Passaic, N.J.
- WILLIAM L. LYALL, Supt., (1908)  
Jersey City Hospital, Jersey City, N.J.
- HELEN B. PAGE, Supt., (1910)  
Memorial Orange Hospital, Orange, N.J.
- DR. H. E. RICKETTS, Supt., (1911)  
Essex Co. Isolation Hospital, Belleville, N.J.
- CHAS. E. TALBOT, Supt., (1904)  
Newark City Hospital, Newark, N.J.
- MISS KATE L. B. TULLY, Supt., (1911)  
North Hudson Hospital, Werhauken, N.J.
- MISS MARGARET A. WALLACE, Supt., (1909)  
General Hospital, Passaic, N.J.
- MISS MARGARET WORTHINGTON, Supt., (1910-11)  
Home for Incurables, Newark, N.J.
- THOMAS R. ZULICH, Supt., (1908)  
Paterson General Hospital, Paterson, N.J.

## NEW MEXICO (3)

SISTER ALEXANDRINE,

St. Joseph's Hospital, Albuquerque, N. M.

F. C. DIVER, M.D., (1909)

Dawson Hospital, Dawson, New Mexico.

WAYNE McV. WILSON, M.D., Supt., (1909)

New Mexico Cottage Hospital, Silver City, N. Mex.

## NEW SOUTH WALES (1)

WILLIAM EPPS, Secretary to Hosp., (1907)

Royal Prince Alfred Hospital,

Sydney, New South Wales.

## NEW YORK (175)

MISS AMY ARMOUR, R.N., Asst. Supt., (1911)

Smith Infirmary, Tompkinville, N.Y.

LEO ARNSTEIN, Trustee, (1908)

Mt. Sinai Hospital, 49 East 82nd St.,

New York City.

MISS LOUISE F. ARNOLD, Supt., (1911)

Samaritan Hospital, Troy, N.Y.

WILLIAM SEAMAN BAINBRIDGE, M.D., Trustee, (1908)

N. Y. Skin and Cancer Hospital,

34 Gramercy Park, New York City.

MISS SUSIE A. BARDEN, Supt., (1911)

Hospital for Deformities, New York City.

O. H. BARTINE, Supt., (1907)

Hospital for Ruptured and Crippled,

New York City.

CLEMENT A. BERARD, Supt., (1909)

French Benevolent Society, New York City.

MISS FRANCES H. BESCHERER, Head Nurse, (1909)

Albany Guild for the Care of the Sick,

Albany, N.Y.

MISS LYDIA E. BETZ, Supt., (1910-11)

Albany Guild, Albany, N.Y.

MRS. R. ELIZABETH BISMED, Supt., (1909)

St. John's Riverdale Hospital, Yonkers, N.Y.

- D. M. BLOOM, M.D., Assistant Supt., (1908)  
Mt Sinai Hospital, New York City. (*Associate*)
- HENRY J. BOSTWICK, Asst. Supt., (1907)  
Clifton Springs Sanatorium,  
Clifton Springs, N.Y. (*Associate*)
- JOHN W. BRANNAN, M.D., Pres., Board of Trustees, (1908)  
Bellevue and Allied Hospitals,  
11 West 12th St., New York City.
- W. P. BROWN, Governor, (1908)  
New York Hospital, 59 Wall St., New York City.
- C. R. BROZILLERI, Trustee, (1910-11)  
Columbus Hospital, Buffalo, N.Y.
- FREDERICK BRUSH, M.D., Supt., (1909)  
Post Graduate Hospital, New York City.
- H. G. BUGBEE, M.D., Supt., (1908)  
Vassar Brothers' Hospital, Poughkeepsie, N.Y.
- MISS SARA BURNS, Supt., (1908)  
New York Skin and Cancer Hospital,  
New York City.
- CHAS. H. BURR, Supt., (1910-11)  
N.Y. Orthopædic Dispensary and Hospital,  
New York City.
- BAILEY B. BURRITT, Assistant Secretary, (1909)  
State Charities Aid Association, New York City.  
(*Associate*)
- MISS NANCY E. CADMUS, Supt., (1905)  
Manhattan Maternity and Dispensary,  
New York City.
- HENRY CALMAN, Trustee, (1910-11)  
Mt. Sinai Hospital, New York City.
- ALEXANDER H. CANDLISH, Supt., (1908)  
New York Eye and Ear Infirmary, New York City.
- J. G. CANNON, Trustee, (1909)  
Hahnemann Hospital, New York City.
- MISS LETA CARD, R.N., Supt., (1910-11),  
Glen Falls Hospital, Glen Falls, N.Y.

- M. CAVANA, M.D., Supt., (1909)  
Oneida Private Hospital, Sylvan Beach, N.Y.
- FREDERICK CHORMAN, Trustee, (1910-11)  
N. E. Memorial Hospital, Niagara Falls, N.Y.
- MISS GRACE L. CLOCK, Supt., (1910-11)  
Women's Hospital, 109th St., New York City.
- REV. GEO. F. CLOVER, Supt., (1907)  
St. Luke's Hospital, New York City.
- O. H. COBB, M.D., Asst. Supt., (1910)  
New York State Hospital, Haverstraw, N.Y.  
(Associate.)
- WM. H. CONDON, Supt., (1909)  
German Hospital, Brooklyn, N.Y.
- W. H. CONLEY, Asst. Supt., (1910-11)  
Metropolitan Hospital, New York City.
- MISS E. P. CRANDALL, (1903)  
257 W. 84th St., New York City.
- MISS ELIZABETH DALY, Supt., (1910)  
Infants' Summer Hospital, Charlotte, N.Y.
- HENRY G. DANFORTH, Trustee, (1909)  
Rochester General Hospital,  
Powers Bldg., Rochester, N.Y.
- WILLIAM DAUR, Supt., (1908)  
Lebanon Hospital, New York City.
- MISS IDA E. DAVIS, Asst. Supt., (1909)  
St. John's Riverdale Hospital, Yonkers, N.Y.
- W. L. DEBOST, Trustee, (1910-11)  
S. R. Smith Infirmary, Tompkinville, N.Y.
- ROBT. DEFOREST, Trustee, (1910-11)  
Presbyterian Hospital, New York City.
- MISS JULIA DUFFY, Asst. Supt., (1910-11)  
State Hospital, Central Islip, N.Y.
- MISS VERA D. EATON, Supt., (1908)  
Lockport City Hospital, Lockport, N.Y.
- MISS NANCY P. ELLICOTT, Supt., (1909)  
Rockefeller Institute Hospital, New York City.



- MISS ARVILLA E. EVERINGHAM, Supt., (1908)  
Rome Hospital, Rome, N.Y.
- C. IRVING FISHER, M.D., Supt., (1901)  
Presbyterian Hospital, New York City.
- J. F. FITZGERALD, M.D., Supt., (1905)  
King's County Hospital, Brooklyn, N.Y.
- MARK L. FLEMING, Asst. Supt., (1910)  
Bellevue Hospital, New York City, N.Y.
- HOMER FOLKS, Trustee, (1910)  
Loeb Memorial Hospital, New York City. N.Y.
- LOUIS J. FRANK, Supt., (1907)  
Beth Israel Hospital, New York City.
- MISS HELEN M. GARRETT, Supt., (1905)  
City Hospital, Amsterdam, N.Y.
- MRS. GERTRUDE GIBSON, Supt., (1903)  
Prospect Heights Hospital, Brooklyn, N.Y.
- S. S. GOLDWATER, M.D., Supt., (1904)  
Mt. Sinai Hospital, New York City.
- WALTER S. GOODALE, M.D., Supt., Supt., (1910)  
Ernest Wende Hospital, Buffalo, N.Y.
- MISS MARY GOODRICH, Asst. Supt., (1905)  
Lawrence Hospital, Bronxville, N.Y.
- DR. C. W. GOODWIN, Supt., (1910-11)  
St. John's Guild Seaside Hospital, New Dorp. N.Y.
- HAROLD C. GOODWIN, M.D., Supt., (1909)  
Albany Hospital, Albany, N.Y.
- MISS DOROTHEA GOTHSON, Supt., (1910-11)  
Swedish Hospital, Brooklyn, N.Y.
- EMIL GREENBURG, Asst. Supt., (1911)  
Beth. Israel Hospital, New York City.
- F. D. GREENE, Secretary, (1910-11)  
Hospital Saturday and Sunday Ass'n. New York City.
- JEROME D. GREENE, Supt., (1910)  
Rockefeller Institute, New York City.
- LEWIS T. GRIFFITH, M.D., Supt., (1909)  
New York Red Cross Hospital, New York City.

- CHAS. B. GRIMSHAW, Supt., (1907)  
Roosevelt Hospital, New York City.
- JOHN GUNN, Supt., (1906)  
Polyclinic Hospital, New York City.
- J. T. HARRINGTON, M.D., Supt., (1910-11)  
Vassar Bros. Hospital, Poughkeepsie, N.Y.
- FREDERICK A. HART, M.D., Supt.,  
Woman's Relief Corps Home, Janesville, N.Y.
- HENRY B. HATHAWAY, Trustee, (1907)  
Rochester Homeopathic Hospital, Rochester, N.Y.
- MISS ELIZABETH HAYDEN, Supt., (1908)  
Red Cross Hospital, New York City.
- MISS S. HENRY, Supt., (1908)  
Newburgh Hospital, Newburg, N.Y.
- MILTON P. HERRMANN, Trustee, (1909)  
Mt. Sinai Hospital, New York City.
- MISS HELEN G. HILL, Supt., (1909)  
Children's Hospital, Buffalo, N.Y.
- W. W. HOPPIN, Gov., (1908)  
New York Hospital,  
52 Williams St., New York City.
- E. H. HOWARD, M.D., Supt., (1909)  
Rochester State Hospital, Rochester, N.Y.
- DR. THOMAS HOWELL, Supt., (1902)  
New York Hospital, New York City.
- MISS DOROTHY M. HUGO, Asst. Supt., (1908)  
Amsterdam City Hospital, Amsterdam, N.Y.  
(Associate)
- MISS JULIA HUNT, Supt., (1910-11)  
N.Y. Nursery and Children's Hospital,  
New York City.
- ARTHUR W. HURD, M.D., Supt., (1905)  
Buffalo State Hospital, Buffalo, N.Y.
- MISS IRENE M. JOHNSON, Supt., (1909)  
Memorial Hospital, Niagara Falls, N.Y.
- MISS MAUDE L. JOHNSTON, Supt., (1907)  
Rochester Homeopathic Hospital, Rochester, N.Y.

- ISRAEL C. JONES, M.D., Supt., (1904)  
Homefor Incurables, Fordham, N.Y.
- MISS LUCY RIPLEY JOY, Supt., (1910)  
House of the Good Samaritan, Watertown, N.Y.
- REV. A. S. KAVANAGH, Supt., (1908)  
Methodist Episcopal Hospital, Brooklyn, N.Y.
- MRS. J. A. KEHELBECK, Trustee, (1908)  
The Jamaica Hospital,  
2195 Broadway, New York City.
- MISS MARY L. KEITH, Supt., (1905)  
Rochester General Hospital, Rochester, N.Y.
- LOUIS KORTUM, Supt., (1907)  
German Hospital and Dispensary, New York City.
- MISS ELIN K. KRAEMER, Supt., (1908)  
Frederick Ferris Thompson Hospital,  
Canandaigua, N.Y.
- ADOLF KUTTROFF, Trustee, (1908)  
German Hospital and Dispensary,  
128 Duane St., New York City
- AMZI LAKE, (1906)  
New York City.
- MISS MARY A. LAUD, R.N., Supt., (1911)  
Mt. Vernon Hospital, Mt. Vernon, N.Y.
- MRS. A. M. LAWSON, Supt., (1902)  
General Memorial Hospital, New York City.
- REV. F. S. LEACH, Ph. D., Asst. Supt., (1911)  
St. Luke's Hospital, New York City
- MRS. BERTHA N. D. LESTER, Trustee, (1910)  
Saratoga Hospital, Saratoga Springs, N.Y.
- MISS JANE E. LESTER, Supt., (1910-11)  
United Hospital, Port Chester, N.Y.
- MISS LINA LIGHTBOURN, Supt., (1906)  
Hospital of the Good Shepherd, Syracuse, N.Y.
- MISS JULIA A. LITTLEFIELD, Supt., (1909)  
Schenectady Physicians' Hospital,  
Schenectady, N.Y.

- MISS ELIZABETH LOUNSBERY, ) 1901 )  
 Ossing Hospital, Ossing-on-Hudson, N.Y.
- GEO. P. LUDLAM, Emeritus Supt., (1902)  
 New York Hospital, New York City.
- MISS FRANCES L. LURKINS, Supt., (1902)  
 Laura Franklin Hospital for Children,  
 New York City. A
- MABEL E. MCCALMONT, R.N.,  
 129 Columbia Heights, Brooklyn, N.Y.
- MRS. M. E. McCARTER, (1910-11)  
 Member Com. Reduction in Mortality,  
 426 E. 26 St., New York City.
- SISTER MARIE, R.N., Supt., (1910-11)  
 Misericordia Hospital, 86th St., New York City.
- MARCIA E. MARTYN, Supt., (1910)  
 Washington Heights Hospital,  
 New York City, N.Y.
- H. E. MONTGOMERY, Trustee, (1908)  
 Buffalo Homeopathic Hospital,  
 Court and Wilkinson Sts., Buffalo, N.Y.
- DR. R. J. MORRISON, Trustee, (1911)  
 Williamsburg Hospital, Brooklyn, N.Y.
- H. J. MOSS, M.D., Asst. Supt., (1910)  
 Mt. Sinai Hospital, New York City. (*Associate.*)
- MISS MARGARET MUNN, Supt., (1908)  
 N. Y. Infirmary for Women and Children,  
 New York City.
- MISS J. E. NASH, Supt., (1910-11)  
 Fordham Hospital, New York City.
- DR. WILLIS G. NEALLEY, Asst. Supt., (1911)  
 New York Hospital, New York City.
- E. NORTON, Trustee, (1909)  
 S. R. Smith Infirmary, Staten Island, N.Y.
- HENRY F. NOYES, Pres., Board of Trustees, (1907)  
 Brooklyn Hospital, Brooklyn, N.Y.
- MISS IDA NUDELL, Supt., (1908)  
 White Plains Hospital, White Plains, N.Y.

- REUBEN O'BRIEN, Supt., (1901)  
Manhattan Eye and Ear Hospital, New York City.
- GEORGE O'HANLON, Asst. Supt.,  
Bellevue Hospital, New York City, N.Y.
- MISS MARY W. OSBORNE, Supt., (1907)  
Brooklyn Hospital, Brooklyn, N.Y.
- W. S. OVERTON, M.D., Supt., (1909)  
Moore-Overton Hospital, Binghamton, N.Y.
- CHAS. S. PITCHER, Dep. Treas., (1910-11)  
King's Park Sanatorium, King's Park, N.Y.
- CÉLESTINO PIVA, Pres., (1908)  
Italian Benevolent Institute and Hospital,  
167 W. Houston St., New York City.
- DR. M. R. PRATT, Supt., (1911),  
S. R. Smith Infirmary, Tompkinsville, N.Y.
- MISS RUTH PENTLAND, Supt., (1911)  
St. Luke's Hospital, Utica, N.Y.
- GEO. M. PRICE, Trustee, (1908)  
Hospital of the Good Shepherd,  
Syracuse, N.Y.
- MISS N. L. PUGH, Supt., (1910-11),  
Tarrytown Hospital, Tarrytown-on-Hudson, N.Y.
- GEO. L. RIVES, Trustee, (1909)  
New York Hospital, New York City.
- THOMAS K. ROBERTSON, Supt., (1907)  
N.Y. City Eye and Ear Infirmary,  
New York City.
- DR. A. S. ROSENBLUTH, Supt., (1907)  
Loeb Convalescent Hospital, East View, N.Y.
- RENWICK, R. ROSS, M.D., Supt., (1904)  
Buffalo General Hospital, Buffalo, N.Y.
- SISTER ST. JAMES, Superior, (1908)  
City Hospital, Ogdensburg, N.Y.
- SISTER OF ST. MARY, Supt., (1910-11)  
St. Mary's Free Hospital for Children,  
New York City.
- GEO. F. SAUER, Supt., (1909)  
Home of Rest for Consumptives,  
Bolton Road, New York City.

- REV. WM. SCHOENFIELD, (1910-11)  
Mem. Evangelical Lutheran Sanatorium,  
1294 Lexington Ave., New York City.
- MISS ANNA L. SCHULZE, Supt., (1908)  
German Hospital and Dispensary, New York City.
- MISS MARY SCHUMACKER, Supt., (1906)  
Sanatorium Hospital, Troy, N.Y.
- NEWTON M. SHAFFER, M.D., Supt., (1909)  
N. Y. State Hospital for Care of Crippled and  
Deformed Children, New York City.
- C. T. SHARP, Asst. Supt., (1911)  
Kingston Ave. Hospital, Brooklyn, N.Y.
- MISS LUCY ASHLEY SHARP, Supt., (1910-11)  
New Rochelle Hospital, New Rochelle, N.Y.
- RICHARD E. SHAW, M.D., Supt., (1901)  
Long Island College Hospital, Brooklyn, N.Y.
- MISS F. D. SILVERMAN, Supt., (1910-11)  
Jewish Maternity Hospital, New York City.
- MISS LAURA A. SLEE, Supt., (1900)  
Women's and Children's Hospital, Syracuse, N.Y.
- J. WILLIAM SMITH, Trustee, (1908)  
Hospital of the Good Shepherd, Syracuse, N.Y.
- MISS MARY AGNES SMITH, Supt., (1908)  
Babies' Hospital, New York City.
- MISS HARRIET SOUTHWORTH, R.N., Supt., (1910-11)  
Thrall Hospital, Middletown, N.Y.
- A. N. SPECTOR, Supt., (1910)  
Har Moriah Hospital, New York City.
- W. H. SPILLER, M.D., Supt., (1908)  
New York Lying-in Hospital, New York City.
- J. EDWARD STOHLMANN, M.D., Supt., (1906)  
N.Y. Infant Asylum, New York City.
- MRS. H. D. STORCK, Supt., (1911)  
Buffalo Women's Hospital, Buffalo, N.Y.
- CHAS. STOVER, M.D., Trustee, (1909)  
Amsterdam City Hospital, Amsterdam, N.Y.
- C. EUGENE STRASSER, Supt., (1907)  
Jewish Hospital, Brooklyn, N.Y.



- FREDERICK STURGIS, Trustee, (1911)  
Presbyterian Hospital, New York City.
- H. K. STURGIS, Trustee, (1910-11)  
New York Hospital, New York City.
- REV. PAUL F. SWETT, Supt., (1909)  
St. John's Hospital, Brooklyn, N.Y.
- MISS MARY J. TAYLOR, Supt., (1908)  
Homeopathic Hospital, Albany, N.Y.
- MISS MARY M. THOMPSON, Asst. Supt., (1909)  
F. F. Thompson Memorial Hospital,  
Canadaigua, N.Y. (*Associate*)
- W. C. THOMPSON, M.D., Supt., (1910)  
West Side Hospital, New York.
- W. V. S. THORNE, Trustee, (1910)  
Presbyterian Hospital, New York City, N.Y.
- GEO. TIMMINS, Trustee, (1908)  
Hospital of the Good Shepherd, Syracuse, N.Y.
- J. G. TIMOLAT, Trustee, (1909)  
S. R. Smith Infirmary, Staten Island, N.Y.
- MISS E. A. TOOKE, Supt., (1910-11)  
Samaritan Hospital, Troy, N.Y.
- RICHARD H. TOWNLEY, Supt., (1904)  
Lincoln Memorial Hospital, New York City.
- HOWARD TOWNSEND, Trustee, (1908)  
New York Hospital,  
32 Nassau St., New York City.
- HENRY S. VAN DUZER, Trustee,  
Presbyterian Hospital, New York City.
- FRANK VAN KLEECK, Trustee, (1908)  
Vassar Brothers' Hospital, Poughkeepsie, N.Y.
- SIEGFRIED WACHSMANN, M.D., Med. Director, (1909)  
Montefiore Home, New York City.
- JOHN B. WALKER, M.D., Managing Director, (1908)  
New York City Private Hospital Association,  
33 East 33rd St., New York City.
- MRS. ELDORA H. WARD, Supt., (1904)  
Jamaica Hospital, Jamaica, N.Y.

- MISS ELSIE WEICKERT, Supt., (1910-11)  
St. Mark's Hospital, New York City.
- A. W. WEISMANN, Supt., (1907)  
Hahnemann Hospital, New York City.
- MISS ROSE C. WELLS, Supt., (1910-11)  
Eastern Long Island Hospital,  
Greenport, N.Y.
- MISS ROSE C. WELLS, Supt., (1910-11)  
Eastern Long Island Hospital, Greenport, N.Y.
- MISS FLORENCE L. WETMORE, Supt., (1908)  
Flushing Hospital, Flushing, N.Y.
- JULIUS M. WILE, Trustee, (1909)  
Rochester General Hospital, Rochester, N.Y.
- WILLIAM C. WILLCOX, Trustee, (1909)  
S. R. Smith Infirmary, Tompkinsville, N.Y.
- IRVING D. WILLIAMS, M.D., (1911)  
American Sanatorium Association,  
New York City.
- ROBERT J. WILSON, Supt., (1907)  
Health Dept. Hospitals, Willard Parker Hospital,  
New York City.
- MISS EDITH WOOD, Supt., (1910-11)  
St. John's Riverside Hospital, Yonkers, N.Y.
- WALTER E. WRIGHT, Asst. Supt., (1910)  
Post-Graduate Hospital, New York City, N.Y.  
(Associate.)
- CHAS. H. YOUNG, M.D., Assistant Supt., (1908)  
Presbyterian Hospital, New York City.  
(Associate.)
- REV. R. A. YOUNG, Supt., (1911)  
Otisville, N.Y.

## NEVADA (1)

- MOTHER MARY AGNES,  
Goldfields, Nev.

## NORTH CAROLINA (12)

- MISS EMILY L. BIZLEY, Supt., (1908)  
Asheville Mission Hospital, Asheville, N.C.

- ROBERT S. CARROLL, M.D., Supt., (1910)  
Dr. Carroll's Sanatorium, Asheville, N.C.
- EDWIN GLADMAN, M.D., Supt., (1910)  
Southern Pines Sanatorium,  
Southern Pines, N.C.
- MISS IDA C. DAVIS,  
Asheville, North Carolina.
- MISS CATHERINE P. HAYDEN, Assistant Supt., (1908)  
St. Agnes Hospital, Raleigh, N.C. (*Associate*)
- J. F. HIGHSMITH, M.D., Supt., (1908)  
Highsmith Hospital, Fayetteville, N.C.
- MISS MARTHA JEAN MACDONALD, Supt., (1910-11)  
Washington Hospital, Washington, N.C.
- H. P. MCKNIGHT, M.D., Supt., (1909)  
Camp Health Sanitarium, Southern Pines, N.C.
- PAUL PAQUIN, M.D., Supt., (1909)  
Asheville-Biltmore Sanatorium, Asheville, N.C.
- RALPH B. SEEM, M.D., Supt., (1909)  
Jas. Walker Memorial Hospital, Wilmington, N.C.
- MISS M. T. SHACKELTON, Supt., (1908)  
Pittman Hospital, Harboro, N.C.
- MISS MARY L. WYCHE, Supt., (1908)  
Watts Hospital, Durham, N.C.

## NORTH DAKOTA (2)

- MISS LOUISE HOERMAN, Assistant Supt., (1909)  
Bismarck Hospital and Deaconess' Home,  
Bismarck, N.D. (*Associate*)
- MISS MARY F. SHIEL, Supt., (1910-11)  
Peninsula Hospital, Salisbury, N.D.

## OHIO (34)

- MISS ELIZABETH AITKENHEAD, Supt., (1910)  
Wooster Hospital, Wooster, O.
- MISS MAUD BARNARD, Supt.,  
Rainbow Cottage Sanitarium, Cleveland, O.
- FRED S. BUNN, Supt., (1910)  
Youngstown Hospital, Youngstown, Ohio.

- C. B. CONNELL, M.D., Supt., (1910-11)  
Ohio State Sanitarium, Mt. Vernon, O.
- MISS SOPHIA M. FOLSOM, Supt., (1908)  
Mt. Sinai Hospital, Cleveland, O.
- DR. J. C. GEORGE, Supt., (1910-11)  
Miami Valley Hospital, Dayton, O.
- MISS MARY E. GLADWIN, Principal, (1905)  
Scranton Road Hospital School of Nursing,  
Cleveland, O.
- MISS LOUISE GOLDER, Supt., (1908)  
Bethseda Hospital, Cincinnati, O.
- MISS TAINSON GRAY, Supt., (1910-11)  
Grace Hospital, Cleveland, O.
- MISS ALMA C. HOGLE, Supt., (1905)  
Cleveland Homoepathic Hospital, Cleveland, O.
- MISS MARY A. JAMESON, Supt., (1910-11)  
City Hospital, Springfield, O.
- REV. G. A. KIENLE, Trustee, (1910-11)  
Emergency Hospital, Mansfield, O.
- JAS. S. KOSOWER, Supt., (1910-11)  
German Hospital, Cleveland, O.
- MISS MARIE A. LAWSON, Supt., (1903)  
City Hospital, Akron, O.
- MISS MATILDA J. LINSKEY, Supt., (1908)  
Emergency Hospital, Mansfield, O.
- MISS FLORENCE N. MAILLENE, Supt., (1910)  
Canfield-White Hospital, Cleveland, O.
- SAMUEL MATHER, Trustee, (1910)  
Lakeside Hospital, Cleveland, O.
- NELL F. PARRISH, Supt., (1910)  
City Hospital, East Liverpool, O.
- W. B. PICKARD, D.D., Supt., (1910)  
St. Luke's Hospital, Cleveland, O.
- MISS KATHERINE McCONNELL, Supt., (1907)  
Ashtabula General Hospital, Ashtabula, O.
- MISS LUELLA McCALPIN, Asst. Supt., (1910-11),  
Greely Hospital, Greely, O.

- C. S. ORDWAY, M.D., Supt., (1910-11)  
East Side Hospital, Todelo, O.
- HERMAN PRETZINGER, Trustee, (1908)  
Miami Valley Hospital, Dayton, O.
- A. J. RANNEY, M.D., Supt., (1905)  
Lakeside Hospital, Cleveland, O.
- J. M. RATCLIFF, M.D., Supt., (1909)  
Dayton Sanatorium, Dayton, O.
- MISS C. M. ROWAN, Supt., (1911)  
Elyria Memorial Hospital, Elyria, O.
- MISS S. A. SIMS, Supt., (1904)  
Youngstown Hospital, Youngstown, O.
- JOHN M. SMITH, Supt., (1908)  
Grant Hospital, Columbus, O.
- MISS LEOLIA P. SMITH, Supt., (1908)  
Martin's Ferry Hospital, Martin's Ferry, O.
- ROSE K. STEMINETZ, Supt., (1910)  
Mary Day Nursery, Akron, Ohio.
- W. H. WEBER, (1899)  
2401 Cedar St., Cleveland, O. (*Associate*)
- H. W. WERTZ, M.D., Supt., (1910)  
The Wertz Hospital, Montpelier, O.
- MILFORD W. WHITE, M.D., Supt., (1910)  
The White Hospital, Ravenna, O.
- J. D. WORKUM, Trustee, (1910-11)  
Jewish Hospital Ass'n, Avondale, Cincinnati, O.

## OKLAHOMA (4)

- JAS. C. JOHNSTON, Supt., (1910-11)  
All Saints Hospital, McAlester, Okla.
- MISS STELLA SHIPLEY, Supt., (1909)  
Bartlesville Hospital, Bartlesville, Okla.
- MISS JEWEL V. STAFFORD, Supt., (1909)  
Muskogee Hospital, Muskogee, Okla.
- MISS GRACE F. WOODWARD, Supt., (1908)  
Baptist Memorial Hospital, Muskogee, Okla.

## OREGON (4)

- HOWARD L. DUMBLE, M.D., Supt., (1909)  
The Cottage Hospital, Hood River, Ore.  
W. T. PHY, M.D., Supt., (1910)  
Hot Lake Sanatorium, Hot Lake, Oregon.  
MRS. A. B. SPAULDING, Supt., (1910-11)  
Multuomah Co. Hospital, Portland, Ore.  
MISS GRACE L. TAYLOR,  
Cottage Hospital, Good River, Ore.

## PENNSYLVANIA (65)

- MISS ELIZABETH W. ANCKER, Supt., (1908)  
Western Phila. Hosp. for Women, Philadelphia, Pa.  
MISS MAUD BANFIELD, Supt., (1900)  
Polyclinic Hospital, Philadelphia, Pa.  
P. K. BECHTEL, Supt., (1902)  
Allegheny General Hospital, Allegheny, Pa.  
MARY BRANSON, M.D., Pres., Board of Trustees, (1908)  
Woman's Southern Homeopathic Hospital,  
1504 Locust St., Philadelphia, Pa.  
MISS ANNA E. BROBSON, Supt., (1910)  
Miners' Hospital, Spargler, Pa.  
DR. J. L. BURGAN, Supt., (1910I--)  
State Hospital, Scranton, Pa.  
MISS E. B. CALLENDER, Supt., (1910-11)  
Bradford Hospital, Bradford, Pa.  
J. R. CODDINGTON, Supt., (1900)  
Samaritan and Garretson Hospitals,  
Philadelphia, Pa.  
MISS MARGARET M. CUMMINGS, Supt., (1909)  
Pittston Hospital, Pittston, Pa.  
DAVID N. DENNIS, M.D., Pres., Hospital Committee, (1908)  
Hamot Hospital, Erie, Pa.  
FRANCIS A. DEVLIN, Supt., (1908)  
Municipal Hospital, Pittsburg, Pa.  
MISS JESSIE M. DURISTINE, Supt., (1909)  
Clearfield Hospital, Clearfield, Pa.  
MISS MARY ECHELBERGER, Assistant Supt., (1908)  
Polk Hospital, Polk, Pa. (*Associate.*)



- MISS CLARA EDGE, Asst. Supt., (1910-11)  
Cottage State Hospital, Mercer, Pa.
- MISS IDA R. FALCONER, Supt., (1908)  
Corry Hospital, Corry, Pa.
- A. D. FELL, Supt., (1910-11)  
St. Luke's Homeopathic Hospital,  
Philadelphia, Pa.
- MISS LOUISE FORD, R.N., Supt., (1910-11)  
Children's Hospital, Pittsburg, Pa.
- MISS M. N. GABLE, Supt., (1909)  
Chambersburg Hospital, Chamberburg, Pa.
- MISS ANNA C. GARRETT, Supt., (1908)  
Frankford Hospital, Frankford, Philadelphia, Pa.
- JOS. GEFFEN, Supt., (1910-11)  
Mt. Sinai Hospital, Philadelphia, Pa.
- MISS L. A. GIBERSON, Supt., (1909)  
American Oncologic Hospital, Philadelphia, Pa.
- CHAS. A. GILL, Supt., (1904)  
Germantown Hospital, Germantown, Pa.
- MISS JANET GORDON GRANT, Supt., (1908)  
Moses Taylor Hospital, Scranton, Pa.
- MRS. JESSIE L. GREENE, Supt., (1909)  
Conemaugh Valley Memorial Hospital,  
Johnstown, Pa.
- MISS MARY C. HANNA, Supt., (1910)  
The Roosevelt Hospital, Philadelphia, Pa.
- MISS CLARA V. HARING, Supt., (1909)  
Allentown Hospital, Allentown, Pa.
- ROBERT E. HASTINGS, Trustee, (1909)  
University of Pennsylvania Hospital,  
Philadelphia, Pa.
- MARY J. HAYS, M.D., Supt., (1908)  
Kane Summit Hospital, Kane, Pa.
- DR. ELLEN E. W. HOWELL, (1910-11)  
Member Women's Southern Homeopathic  
Hospital Ass'n, Philadelphia, Pa.

- MISS ELLEN M. HUNT, Supt., (1909)  
Cottage State Hospital, Mercer, Pa.
- WALTER LATHROP, M.D., Supt., (1901)  
State Hospital, Hazelton, Pa.
- E. F. LEIPER, Supt., (1911)  
P. E. Church Hospital, Philadelphia, Pa.
- J. H. McCLELLAND, M.D., Trustee, (1908)  
Homeopathic Hospital, Pittsburg, Pa.
- JAMES E. MATTHEWS, Supt., (1907)  
State Hospital, Scranton, Pa.
- S. G. MORBON MAULE, Trustee, (1909)  
Hahnemann Medical College and Hospital,  
Philadelphia, Pa.
- N. F. MOSSELL, M.D., Supt., (1910)  
Frederick Douglas Memorial Hospital,  
Philadelphia, Pa.
- JOS. W. MOTT, Steward, (1910)  
Jefferson Hospital, Philadelphia, Pa.
- MISS KATHERINE A. MOYER, Supt., (1909)  
Pottstown Hospital, Pottstown, Pa.
- MISS JEANNE NEWINGTON, Supt., (1909)  
Latrobe Hospital, Latrobe, Pa.
- H. L. ORTH, M.D., Supt., (1909)  
Pennsylvania State Hospital, Harrisburg, Pa.
- MRS. EMMA PFATTEICHER, Trustee, (1910-11)  
Easton Hospital, Easton, Pa.
- JOHN REID, Supt., (1910)  
St. Margaret's Memorial Hospital, Pittsburg, Pa.
- MISS ANNA M. RINDLAUB, Supt., (1909)  
South Side Hospital, Pittsburg, Pa.
- MARIE ROBERTSON, R.N., Supt., (1910)  
Warren Emergency Hospital, Warren, Pa.
- L. A. SCHOLLENBERGER, M.D., Supt., (1910)  
Homeopathic Hospital, Reading, Penn.
- ALICE M. SEABROOK, M.D., Supt., (1902)  
Women's Hospital, Philadelphia, Pa.

- MISS E. L. SHEA, Supt., (1910-11)  
Cottage State Hospital, Mercer, Pa.
- MISS A. B. SINSEBAUGH, Supt., (1910-11)  
Christian H. Buhl Hospital, Sharon, Pa.
- W. B. SOUDER, Supt., (1910-11)  
W. Phila. Gen. Homeopathic Hospital,  
Philadelphia, Pa.
- MISS MARIE SOWA, Supt., (1910-11)  
Easton Hospital, Easton, Pa.
- REV. W. S. STEEN, M.D., Supt., (1902)  
Presbyterian Hospital, Philadelphia, Pa.
- KATHERINE C. STEVENSON, Pres., (1910)  
West Philadelphia Hospital for Women,  
Philadelphia, Pa.
- EWELL STOCKDALE, M.D., (1902)  
Sunny Rest Sanatorium, White Haven, Pa.
- LYDIA WEBSTER STOKES, M.D., Supt., (1909)  
Women's Southern Homeopathic Hospital,  
Philadelphia, Pa.
- MISS ELIZ. SURBRAY, Supt., (1910-11)  
City Hospital, Warren, Pa.
- DANIEL D. TEST, Supt., (1900)  
Pennsylvania Hospital, Philadelphia, Pa.
- CHAS. E. THOMPSON, M.D., Supt., (1900)  
Scranton Private Hospital, Scranton, Pa.
- MISS L. G. TOWNSEND, Supt., (1907)  
Columbia Hospital, Columbia, Pa.
- S. KATHERINE UBIL, Supt., (1910)  
Crozer Homeopathic Hospital, Chester, Pa.
- MISS MARY J. WEIR, Supt., (1908)  
Braddock General Hospital, Braddock, Pa.
- C. D. WILKINS, M.D., Supt., (1908)  
City Hospital, Wilkesbarre, Pa.
- MISS MANDE WILLIAMS, Supt., (1910)  
Titusville, Pa.
- MISS MARGARET S. WILSON, Supt., (1905)  
Philadelphia Orthopedic Hospital, Philadelphia, Pa.

SIMON WINDKOS, M.D., Supt., (1909)

Mt. Sinai Hospital, Philadelphia, Pa.

REBECCA S. YOUNG, Supt., (1910)

Methodist Episcopal Hospital, Philadelphia, Pa.

#### PHILIPPINE ISLANDS (2)

NEWTON C. COMFORT, Supt., (1910-11)

Phillipine General Hospital, Manilla, P.I.

HARRY E. SMITH, Supt., (1909)

Baguio Division Hospital, Baguio, Benguet, P.I.

#### RHODE ISLAND (9)

MISS LUCY C. AYRES, Supt., (1910-1911)

Woonsocket Hospital, Woonsocket, R.I.

W. LINCOLN BATES, M.D., Supt., (1908)

Dr. Bates' Sanatorium, Providence, R.I.

MISS MARGARET S. BELYEA, Asst. Supt., (1908)

Butler Hospital, Providence, R.I. (*Associate*)

G. ALDER BLUMER, M.D., Supt., (1909)

Butler Hospital, Providence, R.I.

MISS E. M. FURSTAL, Supt., (1910)

Woonsocket Hospital, Woonsocket, R.I.

JOHN M. PETERS, M.D., Supt., (1901)

Rhode Island Hospital, Providence, R.I.

D. L. RICHARDSON, M.D., Supt., (1910)

City Hospital, Providence, R.I.

MISS M. M. SUTHERLAND, Supt., (1910-11)

Memorial Hospital, Pawtucket, R.I.

GEO. F. WHITE, M.D., Supt., (1909)

Channing Hospital, Providence, R.I.

#### SOUTH CAROLINA (4)

A. EARLE BOOZER, M.D., Supt., (1909)

Columbia Hospital, Columbia, S.C.

MISS LEILA V. JONES, Supt., (1908)

Roper Hospital, Charleston, C.C.

R. S. LIGIN, Trustee, (1909)

Anderson County Hospital, Anderson, S.C.

MISS MARY E. STELLING, Supt., (1908)  
Anderson County Hospital, Anderson, S.C.

### SOUTH DAKOTA (2)

DR. C. P. FARNSWORTH, Supt., (1910-11)  
Chamberlain Sanitarium, Chamberlain, S. D.  
H. R. HUMMER, M.D., Supt., (1909)  
Asylum for Insane Indians, Canton, S.D.

### TENNESSEE (4)

A. E. CLEMENT, Trustee, (1910-11)  
Galloway Memorial Hospital, Nashville, Tenn.  
W. C. DIXON, Supt., (1910-11)  
Vanderbilt University Hospital, Nashville, Tenn.  
MISS JEANETTE M. PAULUS, (1907)  
Knoxville General Hospital, Knoxville, Tenn.  
MISS KATHERINE M. SHALTO, Assistant Supt., (1909)  
National Soldiers' Home, Tennessee. (*Associate*)

### TEXAS (10)

MISS LOW. E. AMASON, Supt., (1911)  
Hollis Sanitarium, Albilene, Texas.  
B. R. BLUITT, M.D., Supt., (1910)  
Bluitt Sanatorium, Dallas, Texas.  
MISS MILDRED BRIDGES, Supt., (1908)  
Thompson & Johnson Sanatorium,  
Fort Worth, Texas.  
MISS WILMA CARLTON, Assistant Supt., (1908)  
Temple Hospital, Temple, Tex. (*Associate.*)  
MISS A. LOUISE DIETRICH, Supt., (1909)  
St. Mark's Maternity Hospital, El Paso, Tex.  
JOHN T. MOORE, M.D., Trustee, (1910)  
Texas Christian Sanatorium, Houston, Texas.  
DR. D. R. PIVOTO, Supt.,  
Baptist Sanatorium Hospital, Houston, Texas.  
B. J. ROBERTS, Supt., (1909)  
Texas Baptist Memorial Hospital, Dallis, Tex.  
J. R. STUART, M.D., Trustee, (1908)  
Houston Infirmary Sanatorium, Houston, Tex.

- MISS CARRIE WEBSTER, Supt., (1910-11)  
All Saints' Hospital, Fort Worth, Texas.  
W. S. WINTER, M.D., Supt., (1910)  
Lake View Hospital, Ft. Arthur, Texas.

## UTAH (3)

- SISTER M. LIDWINA, Supt., (1908)  
Holy Cross Hospital, Salt Lake City, Utah.  
T. S. PENDERGRASS, Supt., (1908)  
Saint Mark's Hospital, Salt Lake City, Utah.  
JOHN WELLS, Supt., (1906)  
Latter Day Saints' Hospital, Salt Lake City, Utah.

## VERMONT (4)

- MISS MARY A. BURNS, Supt., (1908)  
St. Albans Hospital, St. Albans, Vt.  
MISS ELSIE P. McCLOSKEY, M.D., Supt., (1908)  
Brattleboro Memorial Hospital, Brattleboro, Vt.  
MISS MYRTLE E. MILLER, Asst. Supt., (1910-11)  
Brightlake Hospital, St. Johnsbury, Vt.  
MISS NINA A. SMITH, Supt., (1910-11)  
St. Albans Hospital, St. Albans, Vt.  
DR. L. B. MORRISON, Asst. Supt., (1910-11)  
Mary Fletcher Hospital, Burlington, Vt.

## VIRGINIA (13)

- MISS CELIA BRIAN, R.N., Supt., (1910-11)  
General Hospital, Danville, Va.  
MR. PLINY O. CLARK, Supt., (1910-11)  
City Hospital, Wheeling, Va.  
MISS A. COUSINS MCKAY, Supt., (1909)  
Alexandria Hospital, Alexandria, Va.  
MISS ESTHER MORGAN, Supt., (1910)  
Dixie Hospital, Hampton, Va.  
MISS M. A. NEWTON, Supt., (1904)  
Sara Leigh Hospital, Norfolk, Va.  
CHAS. R. ROBINS, M.D., (Member), (1910)  
Memorial Hospital, Richmond, Va.  
HUGH H. TROUT, M.D., Supt., (1910)  
Jefferson Surgical Hospital, Roanoke, Va.



MISS ROSE Z. VAN VORT, (1907)

Norfolk Protestant Hospital, Richmond, Va.

MISS ANNIE S. WILLIAMSON, Supt., (1908)

Mary Washington Hospital, Fredericksburg, Va.

#### WASHINGTON (6)

MRS. MAYNE E. BARRY, Pres., (1908)

Walla Walla Hospital, Walla Walla, Wash.

A. J. BURROWS, Supt., (1909)

Fannie C. Paddock Memorial Hospital,  
Tacoma, Wash.

MISS EVELYN H. HALL, Supt., (1907)

Seattle General Hospital, Seattle, Wash.

G. W. OVERMEYER, Supt., (1910-11)

Willapa Harbor Hospital, Raymond, Wash.

MISS R. C. ROGERS, Supt., (1910-11)

General Hospital, Hoquani, Wash.

R. S. WELLS, M.D., Supt., (1910)

Northport Hospital, Northport, Wash.

#### WEST VIRGINIA (4)

A. S. BOGGS, M.D., Supt., (1907)

Boggs Hospital and Sanatorium, Cassaway, W. Va.

MISS ELEANOR G. EVANS, Supt., (1910-11)

Jefferson Surgical Hospital, Roanoke, Va.

MISS ELIZABETH LOUNSBERRY, (1901)

1119 Lee St., Charleston, W. Va.

MRS. MARY A. MORGAN, Supt., (1909)

Huntington City Hospital, Huntington, W. Va.

#### WISCONSIN (6)

C. B. CLARK, Trustee, (1910-11)

Theda Clark Memorial Hospital, Neenah, Wis.

J. W. COON, M.D., Supt., (1906)

State Tuberculosis Hospital, Wales, Wis.

MISS ELLA C. INGWERSON, Supt., (1907)

La Crosse Hospital, La Crosse, Wis.

B. LEIDERSDORF, Chairman, Executive Com., (1909)  
Columbia Hospital Association, Milwaukee, Wis.  
(Associate)

F. M. SCHULZ, M.D., Supt., (1907)  
Milwaukee County Hospital, Wauwatosa, Wis.

ELYSIAN THOMAS, Supt., (1910)  
Lakeside Hospital, Milwaukee, Wis.

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## HONORARY MEMBERS.

- 1899  
 DEL T. SUTTON.....Detroit, Mich.  
 157 Alexandrine W.
- 1901  
 ROBERT W. HILL.....Albany, N.Y.  
 Capitol Bldg.
- 1902  
 BYRON W. CHILD.....Albany, N.Y.  
 Capitol Bldg.
- 1903  
 FRANK MILES DAY.....Philadelphia, Pa.  
 801 Penn. Mutual Bldg.
- 1903  
 FRANKLIN B. KIRKBRIDE.....New York, N.Y.  
 37 Madison Ave.
- 1904  
 HERBERT G. STOCKWELL.....Philadelphia, Pa.  
 833 Land Title Bldg.
- 1904  
 PROF. S. HOMER WOODBRIDGE.....Boston, Mass.  
 Institute of Technology.
- 1904  
 CHAS. G. DARRAGH.....Philadelphia, Pa.  
 1430 South 58th St.
- 1904  
 J. M. MOSHER, M.D.....Albany, N.Y.  
 170 Washington Avenue.
- 1905  
 SIR HENRY BURDETT, K.C.B., K.C.V.O.....London, Eng.  
 Porchester Square, W.
- 1906  
 FRANK J. FIRTH.....Philadelphia, Pa.  
 716 Arcade Bldg.
- 1907  
 R. W. BRUCE SMITH, M.D.....Toronto, Ont.  
 Parliament Bldg.
- 1907  
 C. W. PARDEE.....Buffalo, N.Y.  
 Delaware Ave.
- 1908  
 DONALD J. MACKINTOSH, M.B., M.V.O.....Glasgow, Scot.  
 Western Infirmary.
- 1910  
 HON. FRANK T. LODGE, Atty-at-Law.....Detroit, Mich.

## CONSTITUTION.

## ARTICLE I.

The name of this Association shall be "The American Hospital Association."

## ARTICLE II.

The object of this Association shall be the promotion of economy and efficiency in hospital management.

## ARTICLE III.

*Membership.*

Sec. 1. The membership of this Association shall be active, associate and honorary.

Sec. 2. Active members shall be those who at the time of their election are trustees or executive heads of hospitals, without reference to sex, title, or denomination. Any person, once an active member, may continue such membership subject to all rules pertaining to membership.

Sec. 3. Associate members shall be executive officers of hospitals next in authority below the superintendent, contributors to, or officers or members of associations, the object of which is the foundation of hospitals or the promotion of the interests of organized medical charities. Associate members shall not have the right to vote.

Sec. 4. All applications for membership shall be in writing, and addressed to the Secretary, and shall be endorsed by one or more members of the Association. They shall be referred by the Secretary to the Committee on Membership for examination and report. The candidate shall be notified of the result. If elected, he shall become a member of the Association on payment of an initiation fee of \$5.00, which shall also cover his first dues. Any person once an active member may continue such membership, subject to all rules pertaining to membership.

Sec. 5. Honorary membership may be suggested at any meeting of the Association by any member for any person whose services, public or private, may entitle him to such recognition, or for any other person who, in the judgment of the Association, is entitled to such membership.

Sec. 6. Honorary members shall have all the privileges of active members, except voting. They shall be exempt from the payment of dues.

#### ARTICLE IV.

The executive officers of the Association shall consist of a President, three (3) Vice-Presidents, a Secretary and a Treasurer.

#### ARTICLE V.

The executive officers shall be elected at each Convention, and shall serve until the close of the Convention next succeeding, or until their successors are regularly elected and installed.

#### ARTICLE VI.

All vacancies occurring in executive offices between Conventions shall be filled by the Executive Committee.

#### ARTICLE VII.

Amendments to the Constitution shall be submitted in writing. Amendments cannot be acted upon at the session at which they are proposed, but may be at any subsequent session. They shall be passed by not less than two-thirds vote of the members present and voting.

## BY-LAWS.

## ARTICLE I.

*Meetings.*

Sec. 1. The regular meetings of the Association shall be held at the places and on the dates fixed by the Convention or the Executive Committee of the Association. This committee, in conjunction with the President and Secretary, shall also arrange the programs for the Conventions.

Sec. 2. Special meetings may be called by the President, or, in his absence, by a Vice-President, upon the written petition of not fewer than ten (10) members. This petition shall recite the object of the call. The President, through the Secretary, shall give notice of not less than sixty (60) days before the proposed time of such special meeting to each member of the Association, which notice shall also recite the object of the meeting.

Sec. 3. A quorum of the Association shall consist of not fewer than thirty (30) members.

## ARTICLE II.

*Elections.*

Sec. 1. All officers shall be elected by ballot, excepting where it is otherwise ordered.

Eec. 2. A majority of the votes cast shall constitute an election.

Sec. 3. Only active members shall be entitled to vote.

## ARTICLE III.

*Duties of Officers.*

Sec. 1. The President shall preside at all meetings of the Association. He shall appoint all committees unless, by vote of the Association, other provisions shall be made. He shall be, *ex-officio*, a member of all standing and special committees.



Sec. 2. The Vice-Presidents shall, in the order of their rank, in the absence of the President, perform his duties.

Sec. 3. The Secretary shall keep the Minutes of the meetings and the records of the Association in a book provided for these purposes. The Secretary shall furnish to the Committee on Publication, within ten (10) days after the adjournment of the regular Convention, a correct copy of the Minutes thereof for publication in the "Proceedings." The Secretary shall be allowed not to exceed the sum of \$600 per annum to defray cost of clerical assistance.

Sec. 4. The Secretary shall conduct the correspondence of the Association, and shall keep on file all letters and all correspondence, together with all replies thereto.

Sec. 5. The Treasurer shall receive all dues and other moneys of the Association, and shall pay all bills approved by the President and Secretary, and shall submit these accounts, together with a financial report, at the regular meeting of the Auditing Committee, after which he shall present this report, with the endorsement of the Auditing Committee, to the Convention. The Treasurer shall be allowed not to exceed the sum of \$120 per annum to defray cost of clerical assistance.

#### ARTICLE IV.

##### *Committees.*

Sec. 1. The President elected at the regular Convention shall appoint the following standing committees: An Executive Committee of five (5) members; an Auditing Committee of three (3) members; a committee on Nomination of Officers of three (3) members; a Membership Committee of three (3) members; a committee of three (3) on Legislation; a Committee on Constitution and Rules of three (3) members; a Committee on Hospital Progress of six (6) members; a Committee on the Development of the Association of three (3) members, and a Non-Commercial Exhibition Committee of five (5) members, including Chairman.

Sec. 2. The Auditing Committee shall receive and audit all accounts of the Treasurer and all bills contracted on account of the Association, stamp its approval thereon, and return them to the Treasurer for submission to the Convention.

Sec. 3. The Committee on Nomination shall nominate to the Convention the names of candidates for President, three (3) Vice-Presidents, Secretary and Treasurer. The action of this committee is at all times subject to the approval of the Convention.

Sec. 4. The Membership Committee shall receive and consider all names of candidates proposed for membership, and shall report results to the Convention for final action.

Sec. 5. The Committee on Constitution and Rules shall consider and report on all proposed amendments in the Constitution and By-Laws and all Rules of Order.

Sec. 6. The Committee on Hospital Progress shall observe the development of hospital work in the United States and Canada, and shall submit a report of its observations at the Annual Convention of the Association..

The Committee on Hospital Progress shall be subdivided as follows:

- (a) A committee of one on hospital construction;
- (b) A committee of one on hospital efficiency, hospital finances and the economics of administration;
- (c) A committee of one on medical organization and medical education;
- (d) A committee of one on the training of nurses.
- (e) A committee of one on out-patient work.
- (f) A committee of one on hospital accounting.

Sec. 7. The Committee on the Development of the Association shall present annually a report on the further development of the Association's work.

Sec. 8. The Committee on Legislation shall report annually to the Association on all national and state legislation of interest to hospitals or training schools.

Sec. 9. The Committee on Non-Commercial Exhibits shall arrange annually for an exhibit of non-commercial hospital appliances. The chairman of this committee shall be an officer of the Association, to be appointed by the President for a period of two years, and shall be allowed a sum not exceeding \$250 per annum to defray expenses.

#### ARTICLE V.

##### *Dues.*

Sec. 1. The dues of active members shall be Five Dollars (\$5.00); the dues of associate members shall be Two Dollars (\$2.00). Dues shall be paid to the Treasurer of the Association or before each regular meeting of the Association.

Sec. 2. Any member delinquent in his dues more than two (2) successive Conventions shall, upon the report of the Treasurer of adequate notification, be suspended from membership.

Sec. 3. The Treasurer shall notify the delinquent of such suspension, and at the same time the Secretary of the Association, who shall enter it upon the records.

Sec. 4. Any delinquent may reinstate himself upon payment of all back dues, as well as those for the ensuing Convention.

#### ARTICLE VI.

##### *Publication of Proceedings.*

Sec. 1. The President shall appoint three active members of the Association as a Publication Committee, one of whom shall be the Secretary of the Association. It shall be the duty of this Committee to edit and publish the annual transactions of the Association.

Sec. 2. The Secretary shall furnish each active and honorary member a copy of this publication.

Sec. 3. The Treasurer shall, upon the certification of the President and Secretary, pay all bills for the printing and publication of the Proceedings of the regular Conventions.

## ARTICLE VII.

*Guests.*

Members of this Association may have the privilege of inviting special guests to the meetings, with the consent of the President. Guests thus introduced shall be permitted to participate in the discussions.

## ARTICLE VIII.

*Discipline.*

Sec. 1. All charges of violation and infraction of rules or unbecoming conduct shall be referred to a special investigating committee appointed by the President.

Sec. 2. Due notice of the charges shall be given to the alleged offender, in writing, by the Secretary of the Association.

Sec. 3. The Association shall have the right and authority to reprimand, suspend, and expel any member guilty of violation of any of the provisions of the Constitution or By-Laws of the Association, after a full and fair investigation shall have been made.

Sec. 4. A four-fifths vote shall be necessary to sustain the action of such committee.

## ARTICLE IX.

*Order of Business.*

Calling of the Association to order.

Reading of Minutes of previous Convention.

Announcements. Unfinished Business.

Reports of Committees.

New Business.

Presentation of Papers, and Discussion.

## ARTICLE X.

*Amendments to By-Laws.*

No part of these By-Laws shall be suspended, altered, or changed, except as provided for by Article VII. of the Constitution.

MINUTES OF MEETING OF THE THIRTEENTH  
ANNUAL CONFERENCE OF THE AMERICAN  
HOSPITAL ASSOCIATION.

HELD AT NEW YORK CITY, N.Y.

Sept. 19, 20, 21, 22, 1911.

TUESDAY, SEPTEMBER 19—MORNING SESSION.

The convention met at Murray Hill Hotel, Dr. W. L. Babcock, President of the Association, in the chair.

An invocation was pronounced by the Right Reverend Charles S. Burch, Suffragan Bishop of the Diocese of New York.

Hon. Geo. McAneny, President of Borough of Manhattan, delivered an Address of Greeting.

Dr. W. L. Babcock delivered the presidential address.

Adjourned to 8 p.m.

Dr. J. N. E. Brown read a paper, "Notes on European Hospitals," illustrated by sixty lantern slides.

Mr. Edward Stevens read a paper on "Details and Equipment of the Hospital," illustrated by eighty lantern slides.

Dr. R. B. Harris read a paper prepared by Dr. J. H. Kellogg, entitled "The Sanitarium Hospital." This was discussed by Dr. H. M. Hurd and E. B. Smith.

Adjourned for the day.

WEDNESDAY, SEPTEMBER 20, 10.20 A.M.

The President appointed Dr. R. R. Ross, Miss Mary L. Keith, and Dr. J. L. Freeland on the Committee of Time and Place of Next Meeting.

He appointed Dr. P. E. Truesdale to the Committee on Constitution and By-laws, and Rev. W. S. Steen on the Auditing Committee.

Dr. D. L. Richardson read a paper on "Hospital Treatment of Communicable Diseases." This was discussed by Drs. C. J. Hastings, M.H.O. of Toronto; E. B. Smith, H.

M. Hurd, Sharp, Drew, Peters, Ross, Holmes, Freeland, and Mr. Edward Stevens.

Mr. J. M. Cosgrave read a paper on "The Development of Typhoid Fever Among Hospital Workers." It was discussed by Surgeon Austin, Dr. W. P. Morrill, and Dr. Hastings.

Mr. Chas. A. Gill read a paper on "The Foundation of Hospital Efficiency," prepared by Mr. Frank J. Firth.

"Present Day Methods of Giving Anesthetics in Hospitals" was the subject of a paper presented by Dr. Willis G. Neally.

This was discussed by Drs. Drew, Babcock, Seabrook, Truesdale, Mann, Miss Ayres, Mr. Strasser, and Miss Harty.

Adjourned to 2.30 p.m.

#### WEDNESDAY, 2.30 P.M.

The Secretary read an invitation from the New York Commissioner of Charities to visit the city hospitals.

#### TRUSTEES SESSION.

Mr. Henry Van Duzer in the chair.

Mr. R. W. Hebbard read a paper entitled "Hospital Facilities in New York City."

Mr. H. C. Wright read a paper on "Purchasing by a Central Body vs. by Separate Institutions."

Discussed by Dr. Bruce Smith.

W. J. Forbes read a paper on "Standardization and Purchase Agreements Through a Central Hospital Bureau."

The following persons took part in the discussion of the papers: Drs. A. S. Kavanagh, Thos. Howell, C. Irving Fisher, Frederick Brush, R. O'Brien, Miss Cadmus, Miss McCalmont, Dr. R. R. Ross, Dr. H. B. Howard, Capt. Townley, and Dr. Babcock.



Dr. Babcock resumed the chair, and a vote of thanks was tendered Mr. Van Duzer.

Adjournment taken.

THURSDAY, SEPTEMBER 21, 10.30 A.M.

On motion of Dr. E. B. Smith, the Secretary was instructed to forward greetings to Miss Clara Barton.

The report of the Treasurer was then presented (see proceedings.)

It was moved by Dr. Clover, and seconded by Dr. Kavanagh, that a committee be appointed to memorialize Congress with a view to having hospitals receive the same tariff privileges as other educational institutions. Carried.

Dr. Washburn moved for the appointment of a committee to formulate a standard nomenclature for hospitals, a sum not exceeding \$500 to be appropriated for expenses. Seconded by Dr. Winford Smith.

Motion lost.

A revised motion omitting the appropriation was moved by Dr. Kavanagh, seconded by Dr. Ancker, and carried.

Dr. R. R. Ross moved that a committee be appointed *in re* fire and liability insurance of hospitals, and that a sum not to exceed \$500 be appropriated for the purpose.

Motion not seconded.

Dr. J. L. Freeland moved that a committee be appointed to consider the question of a commercial exhibit. Seconded by Dr. Smith.

Carried by vote of 52 for, 38 against.

Miss Emma Anderson moved for the appointment of a permanent secretary to take charge of the non-commercial exhibits, and to be allowed a sum not to exceed \$250 a year to defray expenses.

Referred to the Committee on Constitution and By-laws.

Dr. H. A. Boyce moved that in the opinion of this Association there is absolutely no danger to inmates of dwellings in the vicinity of contagious disease hospitals, if there is no communication between them and the patients.

Motion tabled.

The Secretary then presented the report of the Membership Committee . (See proceedings, on another page.)

Miss Nancy Ellicott presented a paper on "The Future of the Trained Nurse."

Miss Mary Wedley, read a paper on "Hospital Social Service." This was discussed by Miss Louise Brent, Dr. Fisher, Miss Tippet, Dr. Sidney Goldstein, Dr. F. Washburn, Dr. D. Test, Dr. Lindsey, Mr. Ellwood, and Mr. Borden.

Adjournment to 2.30 p.m.

#### THURSDAY, 2.30 P.M.

The President appointed as a Committee on Commercial Exhibits, Dr. Kavanagh, Dr. F. Washburn, and Miss Lightbourn.

Mr. F. D. Greene read a paper on "How to Increase Public Support of Hospitals."

This was discussed by Mr. C. A. Gill.

Mr. Abraham Flexner read a paper on "Hospitals, Medical Education and Research." This was discussed by Dr. H. B. Howard and Mrs. Inglehart.

Surgeon Austin, of the U.S. Army, read a paper on "Relation of Hospitals to Public Health Service."

Adjournment to 8 p.m.

## THURSDAY, 8 P.M.

The evening was devoted to the Round Table Conference for Superintendents of the smaller hospitals. Miss Keith presided. (See proceedings on another page.)

Adjournment until Friday.

## FRIDAY, 10 A.M.

The report of the Committee on Constitution and By-laws was then read. (See proceedings.) Its consideration was deterred until the afternoon session.

Miss Grace McCullough read a paper on "Some Problems in the Dietary Department of Hospitals." This was discussed by Miss E. Anderson, Drs. W. Graham, Howard, Ross, Miss Keith, Miss Burgess, Mr. Parke, Mr. Cosgrave, Dr. Pivoto and the President.

The report of the Auditing Committee was presented. (See proceedings.)

Dr. Truesdale, for the Committee on Constitution and By-laws, added a section to the committee's report having reference to the secretarial allowance. It was decided to consider this at the afternoon session.

Capt. Townley was then invited to the chair to conduct the Question Box. (See proceedings.)

Adjourned until 2 p.m.

## FRIDAY, SEPTEMBER 22, 2.30 P.M.

The report of the Committee on Constitution and By-laws was read and adopted. (See proceedings.)

A motion to appoint a Special Committee to revise the constitution and by-laws was laid on the table.

Rev. A. S. Kavanagh presented the report of the Committee on Hospital Efficiency, Finance and Economics of Administration. (See Proceedings.)

The report of the Committee on Time and Place was adopted. (See proceedings.)

Also that of the Nominating Committee. (See proceedings.)

Dr. Kavanagh presented a report of the Committee on Commercial Exhibits, also a second tentative report, if the first was not acceptable.

The second was adopted. (See proceedings.)

Dr. S. S. Goldwater presented report of the Committee on Central Bureau and Permanent Secretaryship, which was adopted. (See proceedings.)

A vote of thanks was tendered Dr. W. L. Babcock for his work as President; and also one to Miss Aitkens for the splendid non-commercial exhibit of which she had charge.

Adjournment.

PROCEEDINGS OF THE THIRTEENTH ANNUAL  
CONFERENCE OF THE AMERICAN HOSPITAL  
ASSOCIATION.

HELD AT NEW YORK CITY, N.Y.,

SEPT 19, 20, 21, 22, 1911.

TUESDAY, SEPTEMBER, 19—MORNING SESSION.

The convention met at Murray Hill Hotel, Dr. W. L. Babcock, President of the Association, in the chair.

PRESIDENT: If the convention will come to order, we will open our proceedings with an invocation by the Right Reverend Charles S. Burch, Suffragan Bishop of the Diocese of New York.

INVOCATION.

Almighty God, from Whom all good things do come, the fountain of all wisdom, Who knows our necessities before we ask, and our ignorance in the asking, we beseech Thee to have compassion on our infirmities and to grant us those things that for our blindness we cannot ask. Wilt Thou give Thy strength to all whose tasks are heavy or burdens hard to bear? Wilt Thou grant Thy blessings to those who labor in the works of mercy and especially to whom the oversight of the sick and the suffering is committed? Wilt Thou grant them the help of Thy blessing for the fulfilment of their duties with clear minds, with patient endurance and with pure fidelity. Especially do we ask Thy blessing upon this gathering of those to whom our hospitals for the healing of the sick are given. May their deliberations be fruitful for the advancement of true science and sound learning, and in Thy Providence may they become in a very real sense physicians to the souls of men as well as to their bodies as they counsel together for better methods in the fulfilment of their high duties. Wilt Thou grant that more and more they may lodge their trust in Thee, the Great Physician in Whom finally the power of all healing rests. We ask it all in the Name and for the sake of Thy Son, our Lord and Saviour, Jesus Christ. Amen.

PRESIDENT: This municipality is larger in power and population than three-fourths of all States, it is larger in power and population than one-half of the kingdoms of Europe. One of our presidents is now touring in the West, building fences, some say. We have with us another president, the President of the Borough of Manhattan, who will give us a greeting. I take pleasure in introducing the Honorable George A. McAneny.

MR. MCANENY: Mr. President and Members of the American Hospital Association,—I welcome you to the City of New York with great and very peculiar satisfaction. I understand that this is the second, in the course of your thirteen sessions, that has been held in New York, the last eight years ago. We have done a great deal ourselves during those eight years. No doubt you studied us then, no doubt you will study us now. I believe that you will find results well worthy of study. We in our turn are bound to receive from you a very great benefit. The discussion of your papers, the publicity that will be given to your proceedings, and the touch in which our own hospital administration will be placed with you, what you are doing and what you are thinking, is going to help us in innumerable ways, in ways the most practical. The City of New York, during these eight years, has spent, or is spending something like twenty million dollars upon its hospital plants, and in the so-called corporate stock budget recently presented, out of a total of less than \$35,000,000 for all city purposes \$6,400,000 was voted for hospital purposes. You will see that we appreciate not only our responsibilities, but our opportunities to do what every city ought to do for its sick, particularly for those of its sick who must necessarily depend upon the social aid that the city can give.

We have, of course, our own problems that are in the larger view the broad problems with which you deal everywhere. We have some that belong to us peculiarly, because of the complexity of our population, because of the condition under which our people must live, because, in short, we happen to be a city of 5,000,000, the only city of its kind in the world. We feel that we are not far behind in these



things to-day. When you were here before, we felt that we were greatly behind. We still feel that we have lessons to learn and improvements to work out, not only in administration of the hospital service itself and in the handling of the particular institutions and of the things within those institutions, but you come to us at a time when we happen to be debating the broader problem of how the city should organize its hospital department. You will find that we have diverging views upon that subject.

I served by chance as a member of the Commission appointed by the Governor of the State three years ago to revise the charter, and in the discussion, it was at first proposed that we should unite in one department our several hospital activities. That has not yet been done. In the charter now pending at Albany, provision was made until a week ago for changes in the control of the Bellevue and Allied Hospital Service, but without touching the rest of the hospitals. Through an amendment, the status quo is restored and we have this situation, that our hospital service is disjected under the control of three separate city departments, Bellevue and Allied Hospital Service, which is the great central Bellevue Hospital plant with the Gouverneur, Harlem and Fordham branches, the Department of Health, which has the so-called contagious diseases hospital and the Department of Charities, which has those hospitals which happen to be upon Blackwell's Island, and which for some reason or other was also given the building of the great hospital at Sea View, upon which we are spending \$4,000,000.

Our ambulance service is of uncertain character as to where it belongs, the present proposition is to put that under the Department Charities. Many of us believe that a single hospital service should be established that will bring all these together, that will give them the benefits that must flow from a common administration, thus following common ideas and being brought close to common problems that will work out the economies that belong to that sort of thing, the economies not in the total spending, but in the results secured for the money that we do spend. You need never believe that

the City of New York is going one step backward in its present policy of very liberal provision for all its duties in this respect. The objection has been raised that we ought not to put our contagious disease hospitals under such an administration, for the reason, that in a sense police power is required to control those hospitals, and to control the action of inmates themselves, to control commitments, for that matter. We do not accept that, those of us who believe in the other plan, as a final or even good reason. There is no reason in the world why the Health Department should not order commitments as the result of its house to house canvasses and daily work: it has to be in touch with contagious diseases to do that. There is no reason why the Charities Department should not order commitments of those who must depend upon the bounty of the city. We believe, in short, that every minor detail of that kind should readily be handled and that we could bring together in one vast organization the hospital service of the City of New York. Whether that will be accomplished in the near future, remains to be seen. The administration of our Bellevue and Allied Hospitals by the present Board is excellent, we would not do without that, nevertheless, centralization should come first, in our judgment, and if we might have a Department of Hospitals with a single head and a Board of this character behind that head, with a certain amount of veto power, a certain amount of control of matters of policy, we think we would strike what is nearest right. I believe if you find the time, as you certainly will, to look into our institutions, you will appreciate that there is something of real interest to you all, because if we get together, if we put our service upon a concrete basis, we shall be in a better position to work out the solution of the problems with which you deal everywhere.

Take the matter of tuberculosis alone, there are three hospitals dealing with it, the great Sea View Hospital, representing the most advanced type of institutions of that kind, the Hospital Sanitarium at Otisville, under the Health Department, isolated wards and other disjunct departments under the Bellevue Department. The result is that when those who are dealing with the problem of tuberculosis on

the outside wish to provide for their patients they have to go to three places, and they may convince in one place where they fail in others. In order to meet that situation we have established a Bureau of Distribution for tuberculous patients, a bureau to which all must apply in the first instance before being assigned to the particular department of the institution to which they are destined. But that is a poor method, and it will be done away with if we have absolute centralization of authority extending over the entire system. It is so, of course, when it comes to the distribution of expenses. We have the curious anomaly here of our tuberculosis hospitals building an institution at Sea View that is going to cost from four to five thousand dollars a bed, maintaining an institution at Otisville that will cost us \$3,900 a bed. The space area at Sea View will far exceed the dreams of those who have figured upon the necessities of patients in such an institution at any time. At the Metropolitan Hospital on Blackwell's Island you will find, perhaps, 2,000 patients with cots dropped in between the beds and in the hallways to take the crowd that comes there from day to day, conditions that are frightful in a sense to behold, conditions that are relieved as fast as we can provide buildings to do it, but, nevertheless, something of which the City of New York is not proud. If we had had an equalization plant at the beginning we should not have made mistakes of that character.

Let me repeat to you that we are grateful to your Association for coming here. We want you to feel that the City of New York is actively and heartily interested in all that you are going to do, and let me say to you, too, that we most appreciate that in having you here we are having a body of men and women who are doing a part of the world's work toward which all should bow, not only with respect, but with sincere gratitude. We welcome you gladly, and I trust you will call on us for anything that we can possibly do in the exercise of our official relations.

#### PRESIDENT'S ADDRESS.

DR. W. L. BABCOCK, of the Grace Hospital, Detroit, delivered the Presidential address, as follows:

The complaint of the old Frenchman of "The Necessity of Saying Something and the Perplexity of Having Nothing to Say," finds an echo in the minds of many who attempt to write an annual address.

I recall joking with two of my predecessors in this office over the pleasure they experienced in preparing the President's address, little dreaming that I would be forced to feeble attempts at emulation in a year or two.

The convention which we inaugurate this morning is the thirteenth birthday of the American Hospital Association. In point of years its youthfulness is apparent to the mere onlooker. The older hospital specialists realize, in spite of its obvious youth, that the progress it has stimulated and witnessed during its existence has been that of an age crowded into a decade.

The inception of this Association occurred in Cleveland in 1899, when its organization was effected by less than a dozen hospital superintendents of the Middle West. It was named the Association of American Hospital Superintendents. Not one of the charter members who attended the first convention is here to-day.

This stripping of thirteen years, to use a not over-elegant comparison, left his swaddling clothes in Philadelphia in 1902 and put on long trousers in Buffalo in 1906, when its name was changed to the American Hospital Association.

For a few minutes this morning I invite you to look forward with me to the future of hospital work, to which this Association must lend a hand, but before doing so let us turn and contemplate two or three land marks that we have planted on the road to progress during the past few years. In this attempt let it be understood that my sole object is to emphasize anew certain progressive measures to which this Association stands committed.

(1) *Economy of Administration and Efficiency of Organization.* This is our slogan. To the newly-elected superintendent it spells success or failure. To the superintendent of a decade it records a considerable measure of

success. To the older superintendent, whose years of hard work and mature judgment have brought him the commendation of a grateful community, it means eternal vigilance.

Briefly, the following are the principal features that *tend* to promote economy and efficiency :

(1) Increase the responsibility allowed department heads and arrange for daily and systematic personal reports from them.

(2) Establish a cost system of accounting, and 1912 business methods in the hospital office.

(3) Provide adequate supervision of the rear exits of the hospital.

(4) Divorce the work of the executive officer (your work) from as much detail as possible.

These considerations, you will note, are but common and conventional observations. A large monograph or lengthy essay could be written on the Economics of Hospital Administration and the details of Organization, but these are of four necessary adjustments that will provide a foundation on which the superstructure of relative economy and efficiency can be reared.

The necessity for efficient and broad-shouldered heads of departments and the desirability of a cost system of accounting are points beyond argument or emphasis, but are we as superintendents and executives giving the institution its due when we fritter time on detail work that can be performed by any sixty-dollar clerk. It is my conviction that the superintendents of small hospitals are more serious victims of the detail grind than the executive officers of larger hospitals. In other words, the incomplete organization of a fifty-bed hospital necessitates a greater variety of duties and a larger burden of detail on the part of its executive officer than that borne by the superintendent of a four hundred-bed hospital with its established departments.

Free from the detail yoke the executive officer should be able to accomplish much towards perfecting his organization. Free from the office trammel he can spend more time about the institution in consultation or association with heads of



departments; in studying a needed improvement here or a new equipment there. By personal intimacy and association he can ascertain at first-hand the ambitions and desires of his co-workers on the medical staff. He can cultivate the clerical and lay friends of the hospital and from them assimilate much benefit in advice and breadth of view. Better still, if free from the detail fiend, he can choose a quiet vantage point and contemplate for an hour each day the progress of the work, the efficiency of the personnel, the happenings of the preceding day, and build plans for the future.

Among my friends in this Association there may be two or three who have accomplished something in this direction.

In speaking thus of some of the regular and daily features of our work, I recognize that I am indulging in mere platitudes, but platitudes are defined as truisms, however stale or insipid they may be.

(2) *Hospital Literature.* In his annual address at Toronto in 1908, Dr. Goldwater, the President of the Association, stated that it was the duty of this Association to produce a hospital literature of its own. The intervening period of three years has marked a promising beginning.

Briefly summarized: The comprehensive articles on Special Problems in Hospital Administration; The Wage Subject; The Waste Question; The Study of the Appropriation of Public Moneys for the Support of Hospitals; Articles on Hospital Construction; Studies in Social Service Work in connection with Hospitals and Dispensaries, etc.; The published addresses of many specialists in the hospital field, that have appeared in our transactions during the past few years; the publication by the Presbyterian Hospital of New York, of a book on Uniform Accounting and Statistics; the publication by the Association of its report on Training School Curricula and Organization, and the additional report of the committee that investigated the subject of Nurse Attendants and Nurses of Limited Training; finally, the Hand Book on Hospital Management, edited by Miss Aikens, to which several of our members have contributed, etc., etc.



(3) *Hospital Training Schools.* The development of training schools has been marked and the crying need which prompted the demand for a committee to investigate the curricula and organization of training schools by the Association three years ago, has been met by the reorganization of many of the schools of the country. It is safe to say that practically one-third of the hospitals of the country have adopted one of the curricula recommended by the Association.

(4) *Hospital Construction.* I have mentioned the literature of hospital construction and refer to the subject again to emphasize the progress of a decade. Hospitals ten to fifteen years old are becoming obsolete, and it is hoped that the advance of specialism in hospital architecture will standardize the construction and equipment of these institutions. Reaching out constantly for things that are new in equipment and construction we must use the rigid rod of discretion to distinguish between that which is practical among the fads. The insistence of the inventors, the importunities of the supply dealers, and the fads of the specialist in construction keep us alive to the use of the level and the plumb in practice. It has occurred to me that some member of this Association could make himself or herself famous by writing an elegy dedicated to the Hospital Equipment Graveyard. The number of operating tables designed and placed on the market is only limited by the number of surgeons who have acquired a livelihood and a talking acquaintance with their profession. The hospital specialist or architect of tomorrow, who meets with the greatest measure of success will be he who will standardize the details of hospital construction and equipment. That this task may be relatively superhuman can be readily conceived when we recall that the floors in Chicago are of terrazzo and those in Boston of battleship linoleum, or when we stop to consider that the chief of staff of each hospital of the country has his own ideas as to how a suite of operating rooms should be constructed and equipped. Like the Bertillon finger prints, there are no two alike.

And now for the future: What can we do as an Association to further the progress of our work? What can we do as individuals to promote the advance of our individual institution and increase its efficiency to the community? This Association will soon become defunct and go the way of many others if we permit certain ideals, which, at this time are forced upon our attention, to escape our grasp.

(1) *The Prevention of Disease.* Beginning with the broadest specification, it is my conviction that hospital authorities have a duty to perform towards the prevention of disease. In these days of specialism and broad generalization, it has occurred to all of us that the immediate cure of illness is but one of the functions of hospitals, and the progress of our work in the future will bear me out in the statement that the campaign for the prevention of disease, the teaching of the ordinary rules of hygiene, to the public, the instruction of mothers in the care of infants, and the wiping out of infectious and contagious diseases, will be a part of your work and mine, or our successors in days to come. In the large cities of this country the hospital can do more towards signing the death warrant of the abortionist than the district attorneys. With these broad subjects, all of which spell progress, before us, do you wonder at the emphasis placed upon divorce from office and minor detail, early in this address.

(2) *Social Service Work.* Applied social service work in connection with our hospitals and dispensaries is another milestone in our road to progress. Already here in New York, Boston, and other Eastern cities you have developed this work in advance of the West. Lying close to the subject of preventative medicine, it is a requisite addition to hospital organization and each of us should diligently endeavor to affiliate with this service as soon as possible. It is inevitable. It is one of the subjects on our program later in this session and we hope to know more about it.

(3) *Co-operation Between Hospitals.* Several hospitals in a large community can assist each other in many lines of work. In the purchase of supplies; in the oversight of employes; in the establishment of uniform rates; and in many other ways superintendents can be of benefit to each other. Cultivate a close intimacy with your adjacent superintendent. To carry it a step further this can be developed into an organization such as exists here in New York for the purchase of supplies through a central hospital bureau.

(4) *The Hospital and the Teaching of Medicine.* It is my conviction that the hospital engaging to teach medicine in connection with a medical school should be an adjunct to a university. It can be observed that the large general hospital and the proprietary medical school are becoming incompatible. Further, the trend of events leads me to think, although many will differ in opinion, that the teaching of medicine is unwise and out of place in a large number of hospitals. In many ways it is a farce and a makeshift. From a financial standpoint it is out of the question in small hospitals, and the organization of many of the larger hospitals is not sufficiently advanced to allow affiliation with any school. You will agree with me that the organization of a teaching hospital should be radically different from a non-teaching hospital. The teaching hospital, or preferably the university hospital, will, of necessity, in the future, be obliged to maintain wards for special study arranged along the lines of the Rockefeller Institute of your city. That the teaching of medicine in hospitals needs readjustment will be acknowledged by all observers, who have come in contact with the subject.

(5) *Central Hospital Association Bureau.* Another milestone that looms up in the future is the establishment of a central association bureau, where it is hoped that a permanent secretary of this Association may have his offices and become a receiver and distributor of information and

data on hospital subjects. It is immaterial for us at present to know whether this bureau may be established by one of the "Foundations," by one of the Departments at Washington, or by this Association. It is sufficient for us to see it ahead and work for its development. Its establishment largely depends on the growth and influence, financial and otherwise, of this Association.

(6) *Psychopathic Wards and Wards for Special Diseases.* We now recognize that the etiology of diseases of the mind is no different, in many instances, than the etiology of diseases of the body. This fact necessitates an adjustment of our methods of caring for incipient cases of insanity. The curability of the acute insane is decreased by delay in making an accurate diagnosis and providing remedial measures. The experience of New York City, Albany, and other cities with the psychopathic hospital or psychopathic wards in connection with the general hospital, have been such as to encourage every effort towards the development of like institutions the country over. In many cities the most disastrous problem with which the hospital and poor authorities; the police and charity associations have to deal, is the temporary care of the mentally diseased, pending a diagnosis or commitment to an institution. That special buildings or wards for the insane can be satisfactorily managed in conjunction with general hospitals has been demonstrated beyond dispute, not only at Albany and in this city, but at Ann Arbor and two or three other cities. The affiliation of the psychopathic service with the general hospital is not without its stimulus to the alienist and gives the patient the greatest assurance of an early recovery.

(7) *Preliminary Training of Nurses.* The wonderful advance in medicine and surgery insistently demands progress in every department of hospital work. The lack of proper material for pupils in our training schools is so great that it has become necessary in most schools, to accept for training, material lacking a good English education and much

of the fundamental training of life. To prepare this raw material for nurse training bids fair to become an important function of the training schools of our hospitals or of special schools independently maintained, or allied to a group of institutions organized for the care of the sick. The preliminary training of nurse pupils is as essential to the foundation of good nursing as the preliminary training of doctors is to the efficiency of scientific medicine. If you have not established a preliminary course of training for nurse pupils in your hospital, of from three to six months' duration, it will sooner or later be forced upon your attention as a distinct evolution in the progress of our work. The recommendations of the Special Committee on "Training School Curricula and Organization" of three years ago marked the beginning of this elementary work for most hospitals.

(8) *The Compilation of Hospital Practices; The Collective Study of Hospital Therapeutics, and Standard Medical and Surgical Procedures.* The useful work carried out by Dr. Rice at Bellevue several years ago is still remembered by many of the older hospital authorities. It is a matter of astonishment to me that the methods developed by him, at a time when chaos was spelled with large capitals, has not been more generally studied by the medical superintendents of many of our institutions. Following this lead, at the present time, great benefit would result in an authoritative demonstration of the anesthetic problem in hospitals, the standardization and administration of serums, the establishment of a legitimate standard for the use of alcoholic stimulants, and a permissible latitude or license for the use of sedatives. That these subjects have been worked out for the House Staffs of some of the larger hospitals is known to many of us, but the woman or lay superintendent of the isolated or small hospital is constantly harrassed and burdened with the greatest uncertainty and doubt as to legitimate practices or customs. The study of this problem should be undertaken in

conjunction with members of the medical profession or the attending physicians, who are largely responsible for the position in which the hospitals are placed. It is a matter of common knowledge that there are many hospitals where three if not five different anesthetics are administered for the same operation within a month. The by-laws of this subject are extremely intricate and numerous, best illustrated by the fact that several of the hospitals of this country have forbidden the use of iodoform, and at least one, that of crude oil.

(9) *The Training of Superintendents and Department Heads.* Of this subject you have heard something during the past two or three years. Our progress demands that our superintendents and heads of departments, our dietitians and housekeepers, have a full measure of training prior to the assumption of their duties and responsibilities. To acquire efficiency in actual practice, by hard knocks and experience, has proven detrimental to the progress of numerous institutions and wrecked the careers of promising individuals. It is a duty incumbent on the large general hospitals of this country to provide a means for the practical training of desirable candidates for institutional work.

(10) *Homes for Hospital Domestic and Employes.* The standard of our domestic service is shamefully low. On account of wages paid, the absence of tips, the isolation of the hospital, and the alleged revolting nature of hospital work, the personnel of our domestic departments is of the lowest. That this condition is contrary to economy of administration and efficiency of service is well known. The keystone to improvement in this direction, on the part of hospitals of a hundred beds or over, is the establishment, or building of a home for domestic employes. Will one of my hearers gainsay the statement that the establishment of homes for nurses has increased the efficiency of the training school department? In your list of improvements for the



future, keep constantly before your Board of Trustees, this desirable addition.

(11) *Nomenclature of Diseases.* The hospitals of this country have a duty to perform in the arrangement of a nomenclature and classification for the standarization of the statistics of the medical and surgical departments. An excellent working classification with a nomenclature has been published by the Board of Trustees of Bellevue and Allied Hospitals. This nomenclature was the work of its Committee on Clinical Records. The American Medical Association has also taken up the matter of standardizing the nomenclature of diseases. The International classification has been revised up to 1911, and these three compilations provide an array of well-studied material, which we should render available for our use. It is probable that the nomenclature of one of these compilations could be adapted to standarize our statistics, but some work would have to be done to simplify one of these classifications for publication in our annual reports.

It is my conviction that this Association should, at an early date, authorize its President to appoint a committee to take up this subject. This committee should be granted an expense allowance sufficient to cover the work. If a uniform nomenclature and simple classification can be adopted by this Association and published in pamphlet form, it would quickly standardize the hospital statistics of this country.

(12) *Hospital Insurance.* I wish to recommend that the incoming President be authorized to appoint a committee to investigate the subject of hospital fire and liability insurance. It has come to my notice quite accidentally during the past year, that there is a great variation in the rates and premiums charged hospitals in different parts of the country, a variation not wholly dependent on the nature of the risk or the style of the construction. After a brief correspondence, my belief was confirmed that many errors are due to ignorance on the part of the trustees and superintendents who place the

insurance, and, possibly, some can be attributed to the cupidity of the local agents. This may be illustrated by stating that a hospital in New York City, with a valuation of one million dollars, is paying a lower premium per year than a recently built hospital in a city of the Middle West, valued at \$350,000.00. I would illustrate this further by stating that another hospital of about fifty beds is paying nearly one-half of its endowment income for insurance. In addition to fire risks, it should be the work of this committee to determine to what extent hospitals are justified in carrying liability insurance for employes, elevators, and mechanical equipment. This committee should be empowered to expend a sufficient sum of money to conduct a thorough investigation, to engage an insurance specialist for a short period of time and to publish its findings in pamphlet form, after presentation to the Association.

Finally, let me emphasize that the efforts of this Association should be towards the standardization of our work in all departments. The curricula of our training schools and the financial reports and professional statistics of our annuals should be made uniform. An economical standard administration should be sought and the organization of the working personnel of the hospital be maintained on lines of known efficiency.

That the trend of the times is working to this end may be pointed out from various viewpoints. In all of our cities the municipality or the health and charity boards are constantly acquiring more supervision and more authority over privately managed hospitals. In some localities this supervisory power will come from the State. It is inevitable that this inspectorship or custodial control will demand a standardization of organization and conduct, uniform at least in cities and states.

That we may work forward to this end, I have indicated in this talk a few of the ideals to be sought in the future. A

few hours more will end four years of official connection with this Association, and it will be my greatest pleasure to step into the rank and file of the membership and work shoulder to shoulder towards the consummation of the good things to be sought.

PRESIDENT: Before we close our session this morning, I want to call your attention to the exhibit in the room at the left, which is assuming large proportions. This afternoon we have a vacancy. We purposely placed our second session to-day for the evening to give you a chance to do your shopping and see the town. You know it is much more respectable in New York to do the town in the afternoon than in the evening. To-night at 8 o'clock we have our second session, and two papers will be illustrated by stereopticon, and I grant you that it will be very interesting. Those who have not registered, I hope will do so as early as possible at the Secretary's Office, and those who are not already members of the Association are invited to join.

Adjourned to meet at 8 p.m., same day.

#### TUESDAY—EVENING SESSION.

PRESIDENT: The first subject on our programme this evening is by Dr. J. N. E. Brown, Secretary of the Association.

## EUROPEAN HOSPITAL NOTES.

DR. J. N. E. BROWN, SECRETARY A. H. A., TORONTO.

It was my privilege to spend a part of the last summer, in company with my friend, Mr. Stevens, of Boston, in visiting hospitals in some of the European centres. These included Amsterdam, The Hague, Utrecht, Hamburg, Berlin, Dresden, Vienna, Paris, and London. Our President honored me with a request for a few notes and reflections on what I had seen, which I gladly give to the Association.

## HOSPITAL SUPPORT.

In Great Britain, where the system of voluntary hospitals has obtained for centuries, continuous urgent appeals for assistance appear in the advertising columns of the daily papers. In response to these appeals reports are published at intervals of moneys received from such sources as Hospital Sunday funds, some big dinner under Royal patronage, or other social function. Once in a while one may read that a hospital has been remembered in the will of some rich old gentleman, who has, perhaps, been unobtrusively visiting the hospital for many years.

In contrast to this precarious system of support, we find that the Continental hospitals depend on the public purse for their maintenance, and are quite independent of the benevolence of wealthy philanthropists.

In Paris, hospitals are supported by the city, and are governed by a Board of Charities, which has likewise the supervision of asylums and of poor relief generally.

In Vienna, the hospitals look either to the city, the province or the state for maintenance; and, though for a long time, none of these bodies wanted to shoulder the responsibility, yet the hospitals have been maintained through the aid of one or the other of them.

Hospitals in Holland are similarly supported, but receive in addition a certain income from patients who are able to pay.

Hospitals in Germany are built and supported by the State. Some of them, the Virchow, for instance, also receive pay from patients.

In America, excepting Pennsylvania and some of the Canadian provinces, not many hospitals receive State aid, as most of you are aware. Here and in Great Britain hospitals are supported mainly by the aristocracy of wealth; on the Continent by the democracy. While in many respects the former are better managed than the latter, yet, I must say, from the point of hospital maintenance, there is no question in my mind that the easier and better method of raising money is to get all you need from all of the people, rather than a part of what you need from a few of the people.

Through the years which shall intervene between the present and the time when that ideal condition is reached, let us be thankful that so many are disposed to give of their means for this purpose.

At the time of our visit to London, a committee from the leading voluntary hospitals of Great Britain was interviewing the Chancellor of the Exchequer and pointing out to him how his Insurance Bill, if passed in the form it then was, would decrease the revenue of the hospitals, and, perhaps, necessitate their closing.

The Chancellor's reply was significant: "The Government," said he, "cannot allow the hospitals to be closed."

In view of the fact that 45,000 of the infirm poor in London are supported by taxation, it may not be long until the remaining 10,000 cared for in the voluntary hospitals, are maintained in part or in full at the public expense.

Another result of this paucity of money for the support of voluntary hospitals was impressed on me while being shown through the medical teaching department of one of the large London hospitals. The Professor who accompanied

me complained that the college authorities had only about one-half the amount of money necessary to carry on up-to-date methods of teaching medical students. Surely the institutions which train the men who are to look after the health of the nation should be kept in the highest state of efficiency, and, hence, should not depend for their support on a comparatively few well-disposed individuals, but upon all the people. The recent report of the Carnegie Committee would indicate that in the interests of public safety most of the privately supported medical schools in America should be closed. Their existence is a farce and reflects discredit on the medical profession.

Let us look at Germany.

In the large teaching hospitals, not only does the State supply a full equipment for the care of the sick, but also for the training of medical students. One sees commodious and well-equipped laboratories for chemical, physical, and bacteriological investigations. There is also a full staff of assistants at the command of the investigator, the teacher and the professor. Not only is the condition of the patient elucidated for his own benefit, that he may receive intelligent treatment; but also for the benefit of the coming physicians and surgeons, who will convey the valuable knowledge thus acquired throughout the country.

Do you suppose for a moment that Germany would abandon this general support of her hospitals and medical colleges and resort to the voluntary system of Great Britain, or the partially voluntary system of America?

#### HOSPITAL ADMINISTRATION.

It is a common custom in Holland and Germany to have as superintendent or director of a hospital a medical man, who, in addition to his administrative duties, has charge of a clinic as well, or undertakes the specific treatment medically of a certain number of patients. In some instances, we found



the director busy with his patients, during which time, there appeared to be no one on duty in the head office who could act for him.

In such cases anyone seeking to transact business or confer with the chief executive would be required to wait an undue time.

The writer is of opinion that a medical man, *ceteris paribus*, makes the best sort of director of a large hospital. But, if he is appointed to fill such a position, he should be relieved of work which belongs to the medical staff. The proper administration of a large hospital demands the sole attention of the head. He should not even be required to prescribe for nurses or servants, which duty is sometimes assigned to him. I was told of one administrator who kept a nurse suffering from a sore throat and a high temperature, on duty for two or three days after the onset of these symptoms. She transmitted diphtheria to several inmates of the hospital, including patients. My informant, a member of the medical staff at the time, stated that the chief officer, though a doctor, had had so little active practise during the twenty-odd years of his administration, that he was not sufficiently alert in the matter of diagnosis, and was no longer *au fait* with the latest ideas and procedure in medical practise.

In a large hospital in a German city, Mr. Stevens, my travelling companion, had asked permission of the director to be allowed to take some photographs of various novel features in the place. The favor being granted, he had reached the kitchen, when he was accosted by a gentleman, who, considerably surprised, inquired what right he had there. Explanations followed, wherein it was learned that the hospital had two directors of equal status, one in charge of the purely medical side of the work, the other, called the technical director, in charge of the kitchen, laundry, engineering, supplies, etc.

It is the opinion of the writer that a hospital, large or small, should have but one head, and that the work of that head in a large hospital should be administrative only.

## MEDICAL ORGANIZATION.

There is considerable similarity between the medical organizations of hospitals in Great Britain and those of the United States. In making appointments somewhat the same methods are employed. Able men, who serve without pay, are chosen. There are several seniors of equal status appointed in the chief divisions of medicine and surgery, each of whom is given one or more assistants. House officers are relatively few in number, serve for one or possibly two years and are not paid.

In continental hospitals members of the visiting staff are servants of the State, they are paid for their services and often move from one hospital and teaching centre to another. Each department has one head, unless the hospital is a large one, in which case there may be two clinics in medicine and two in surgery presided over by chiefs of equal status. The other departments—gynaecology, obstetrics, etc., have each one head. In the medical and surgical clinic there may be sub-divisions in charge of certain specialists, who are thus able to make intensive studies of certain diseases. One finds skin and venereal diseases under a separate chief, and the patients suffering from such in a building by themselves.

Separate groups of buildings or portions of buildings are assigned to certain sorts of cases; and much provision is made for laboratory investigation and research in all departments. Laboratories in the medical and surgical departments of the new buildings of the Charity Hospital, Berlin, are constructed as a part of the hospital or ward unit. These large laboratories enable the workers to carry on their bacteriological and chemical investigations in a much more convenient way than when placed in more or less remote buildings. The students are not limited by lack of apparatus and helpers, as was found to be the case in many places in this country by the compilers of the Carnegie report.

The various departments in the German hospitals are well manned with resident medical officers. These men are on salary. They serve three and four years. In some of the hospitals even the chiefs of the departments are resident and paid.

The only hospital in America where I have seen this German method of organization is in the Johns Hopkins Hospital at Baltimore; and, I believe, the work done in that institution during the past fifteen or twenty years has been made possible, to a large extent, by the type of organization, and amply justifies its adoption.

In Great Britain and America the chief interest generally of the head of a hospital service, and of his assistants, is their private practises; hospital work is secondary. In Germany, it is largely the reverse. In America, under present conditions, we cannot expect ideal results. Where a hospital is dependent for its maintenance on voluntary contributions, it has been found prudent for it to have as many friends among the resident medical men of the town or city in which it is located, as possible. The larger number of competent medical men that are appointed on its staff, the more private paying patients it will receive, and the easier it will be to keep its revenue on a level with its expenditure. This point was well brought out by Dr. Kavannagh in his paper at the Toronto meeting of this Association.

This is one of the points to be thought of in considering the idea of trying to introduce German methods of medical organization into our American hospitals.

To work out the problems connected with the study of disease and cure, or to supervise their working out, the chief of clinic and his assistants require more time at their disposal than the men in the average American hospital give—more time than they can afford to give. To do this work properly means hours of hard daily labor. Too often, the visit of the hospital physician is a hurried one, and the work of investigating his cases and their management is left in the hands of inexperienced house officers.

The visiting chiefs in all departments should be familiar with all the more recent methods of inquiry and research; and should have a practical knowledge of the technique of all the more common apparatus used in diagnosis and treatment. This is a great strength to a man, particularly if he be a teacher. If he can with facility make a differential blood count, "do a Wasserman, or widal," make a lumbar puncture and intelligibly examine the fluid withdrawn, analyze stomach contents, determine the significance of a gross or minute pathological section, use the sphygmomanometer, test electrical reactions, know what he sees through the fluoroscope and has the time and inclination to roll up his sleeves and do them, he is the man who will be of great value to a hospital. That this sort of work is not done in hospitals may not be the fault of the visiting staff. The administration has its part to do: All necessary apparatus for such investigations should be provided; enough skilled assistants and servants should be engaged to do the purely routine, mechanical and clerical work.

These ideal conditions are approached in Germany; but to realize them more nearly in America and Great Britain, I am of opinion that the unitary system of organization should be introduced, providing the hospital has sufficient financial strength to be independent of the favor of its visiting staff.

The best man available should be sought for to direct each of the several services, medical, surgical, gynaecological, etc. He should be given or allowed to select first-class assistants. There should be plenty of resident officers, the chiefs of which should be retained at least three years. Men who would be willing to serve in such work should be allowed a good salary, and permitted, perhaps, to do a certain amount of purely consultant work.

This would raise the status of medical education, the sick would receive much more consideration of their condition, and the people at large would be the benefactors.

## HOSPITAL CONSTRUCTION.

The larger hospitals of the Continent may be divided roughly into three classes, in so far as the grouping of buildings is concerned. In the first class you see a large number of low pavilions (chiefly one story) scattered over a large area of ground; in the second, a block or blocks of buildings, some three-storeys in height, completely surrounding a large court, and covering an area considerably smaller than the first sort; while the third consist of a series of detached pavilions, two, three or four storeys in height, set more or less regularly surrounded by lawns and spacious gardens, with plenty of trees and flowers. Examples of the first type are seen at the Eppendorf at Hamburg, and the Virchow in Berlin. The second sort are exemplified by the old municipal hospitals of Paris—the Beaujon, La Charite, La Pitie, and others; the third, by the Charity Hospital, Berlin, the West End Hospital of Charlottenburg, and the new hospital at Rixdorf.

It appears to me that the tendency in Europe is to build the hospitals of to-day of pavilions detached, but nearer together than was the fashion twenty years ago. In America and Great Britain there is more of a tendency to spread out hospital buildings than there was formerly.

In most of the Continental hospitals visited it was gratifying to see the ample and beautiful grounds surrounding them. The Eppendorf looks like a little town lost in a forest. The Virchow is spread through over sixty acres of woodland. In London, on the other hand, many of the leading hospitals, are crowded on all sides by mercantile houses and subject to the din of traffic—Charing Cross, King's College, Westminster, St. George's, St. Bartholomew's, and a number of others. The new King's College Hospital, however, has much more elbow room and will serve a large section of the great metropolis that is now hospitalless. We had to travel some miles into the country to reach the mag-

nificent new hospital which the corporation of Rixdorf has provided for its sick. All about are farms of waving grain-fields and rich meadows; surely an ideal site for a home for the sick.

The sunny and wooded grounds of the Wilhelmina Gasthuis, Amsterdam, are divided for the separate use of the various inmates. One plot is marked off for one class of nuses; another for another; another for nurses who serve in the contagious pavilions; another for the male employes; another for the female. A wire fence thirty feet distant from the street keeps the ambulant patients convalescing from contagious diseases that distance from their relatives who, peering through the fence at the street line, are able to see them and converse with them.

#### WARDS.

The general wards of the European hospitals are considerably larger than those of our hospitals in America; they often provide for the accommodation of thirty or forty patients. We frequently found them overcrowded. Ceilings, as a rule, are 16 feet in height; sometimes more; the maximum being reached in the beautiful gothic British hospital in Paris, in which the arch of the ceiling must be at least 35 feet from the floor. Floors are of Terrazzo, tile or wood, and battleship linoleum. French double windows, with transoms, are, I should say, the most popular.

On the Continent I do not remember seeing any sanitary towers at a distal end of the wards, which one finds universally in Great Britain; nor did I notice that they were often placed at the proximal end, as one generally finds them in America.

In the long double pavilions of the Virchow, the accessory rooms are placed centrally, the ward for the male patients being on one side of them, that for the female on the other.

In the Welheilmina, Amsterdam, pavilions run east and west. The ward unit is rather unique. The patient enters through a double reception room; in the outer his clothes



are removed, and after disinfection handed to his friends who take them home. Passing through the inner ante-room he turns into a small ward containing about ten beds. If he is not in a serious condition he remains here with the non-serious and convalescent patients. If seriously ill, he passes through this ward into a second *en suite*, containing the same number of beds as the first ward. Here all the serious cases are kept. A common toilet suite serves both wards. A small serving kitchen and two bathrooms are attached. These dependencies are all on the north side of the pavilion. When the patient is ready to leave the hospital he is taken into one of the bathrooms, given a bath by a non-exposed nurse. His friends meet him here with his clothes. The above-described arrangement is duplicated on the other side of the entrance hall for patients of the opposite sex. I may add that the nurses who work in this pavilion have their meals in a small dining-room remote from the ward.

#### BATH HOUSE AND DISINFECTION HOUSE.

There are two buildings found in connection with the European hospitals which are worthy of special notice by a transatlantic visitor interested in hospital construction: the bath house and the disinfection building.

In the bath house rooms are provided for giving baths of all kinds, which are most essential to the best treatment of diseases of the skin, kidneys and nervous system.

The disinfection house is usually a two-storeyed building, the lower storey of which has two divisions, in one of which the infected articles are collected. The disinfection chamber intersects the intervening wall. Into this the clothing, mattress, blankets, etc., are placed and exposed to steam and formaldehyde, and, when thoroughly disinfected, withdrawn from the opposite end of the disinfecting chamber into the clean compartment. Special laundry machines are available for the disinfection of linen and other washable material. Infected underwear is disinfected by boiling, and,

after being wrung out, passed over in a damp state to the wash house. A furnace or furnaces in the disinfection building consume the collections of dust, soiled bandages, etc. In some of these houses in a suite of small rooms provision is made for the disinfection of isolation patients, and of the workers in the disinfection department, e.g., Charlottenburg, West End Hospital, Germany.

In some hospitals one sees attached to each pavilion a small pair of rooms with a tank filling a space in the intervening wall. The infected articles are taken into one compartment, placed in the tank which contains disinfecting solution, and, afterward, withdrawn from the other half of the tank in the other compartment.

In the infectious pavilions there are apparatus for sterilizing the stools, urine, sputum and other excretions with steam or hot water. The water which has been used for bathing is disinfected in the tubs by the use of chemical disinfectants. The waste water from the infectious pavilions is collected in a special disinfecting pit and treated with chloride of lime, and then allowed to escape. The effluent from the apparatus which disinfects the excretions is piped off in some places to irrigated fields.

I learn that there is much less cross infection and house infection in European hospitals than we have on this side of the Atlantic. The provision I have above attempted to describe to secure medical as well as surgical asepsis and antisepsis explains in great part the reason.

#### VENTILATION.

In Germany, as in the United States, opinion and practice vary as to the merits of different systems of ventilation. In one of the large Berlin hospitals, completed in '96, the ventilation is secured in somewhat the following way:

In the underground floor of each of the pavilions are placed one or more ventilating fans, according to the requirements. These draw in fresh air from vertical little air

houses. The air passes through a chamber for straining out the dust, a cotton wool filter being used. The air is then driven into a steam-heated chamber, and from here through distributing channels, and thence through wall channels into the different rooms. As the local climate is sufficiently humid, the air is not moistened, as we see done in some places. The foul air is withdrawn from each room by sufficient outlet channels, which extend to the roof storey and terminate in a chamber in front of an exhaust fan. It is sucked from here and driven through ridge turrets into the open. In addition to this mechanical system, provision is made for natural ventilation through trap windows. The ventilating apparatus of the lavatories, kitchens, and sink-rooms is made particularly effective, in order to quickly carry off the vapors and mal-odors which form there.

One of the leading hospital architects of Germany, whom we interviewed, expressed the strongest objection to the plenum system. "The great difficulty," said he, "is to keep the intake pipes free from dirt. When the fans which propel the air are set going, clouds of fine dust are pumped into the room, which condition is intensified by the too rapid rate at which the fans are often operated. Moving air carries dust. The rate of its admission to a room should not exceed one and a half metres a second. The filters have been taken out of the schools in Berlin. In Cologne," he continued, "fresh air is brought from the street directly to the radiators without the intervention of any mechanical devices."

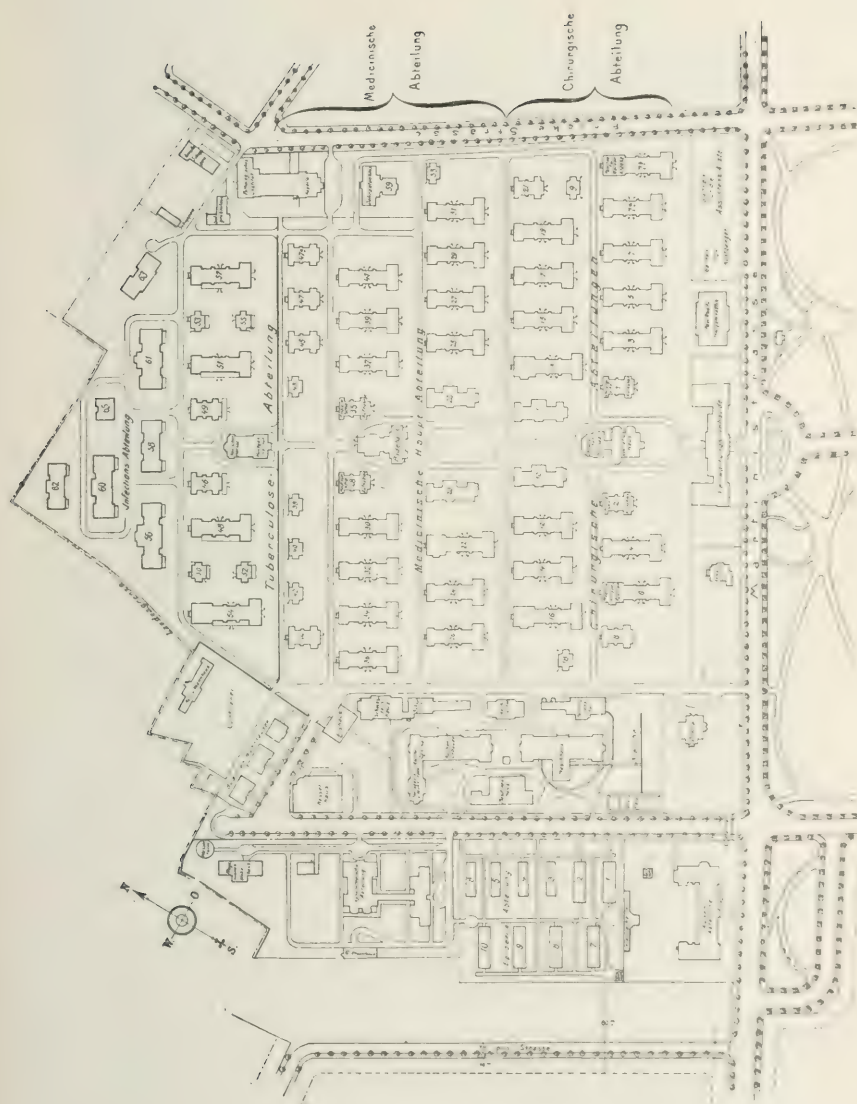
In the St. Georg's Hospital, at Hamburg, the greatest pains are taken in ventilating their new operating room. The air is drawn by electrically-driven fans into a room in the basement. It passes first through a large box filled with fine pebbles. This strains out all particles of dust and smoke. The air is then forced through a box containing layers of sand of different degrees of fineness. This strains out the bacteria. It then enters the operating room and is dis-

charged through openings in the walls. I may add that after operations live steam is injected into the room with the object of destroying any infectious material left in the room. Just how far all these precautions are necessary or advisable, I am not prepared to say. The general opinion is that both these procedures are works of supererogation. I should not like to venture an opinion until I have compared their statistics as to pus with other places where these precautions are not taken.

To my mind, the best system of ventilation has yet to be worked out. I am of opinion that in temperate climates fresh air strained if necessary should be admitted near the floors through the required number of openings, allowed to warm against charged hot water or not too overheated steam radiators, be drawn off near the ceiling through several openings which may lead into one or more pipes which are heated by steam and have at their terminal an exhaust fan, the fan to be used at such times when the draught caused by the heated pipes is insufficient. This plus natural ventilation by windows, transoms, fireplaces, etc., appears to me to be most satisfactory.

To sum up: I have tried in this paper in a brief way to indicate some of the points of difference noted between our hospitals and those across the Atlantic in respect to hospital administration, hospital maintenance, hospital construction, and medical organization.

I will show you sixty slides illustrating hospital sites, grouping and style of building, plan of wards, ward interiors, operating rooms, bath houses, disinfecting houses, etc.



The Eppendorf Hospital

The Eppendorf Hospital at Hamburg is one of the most complete hospitals in the world. It accommodates some 2,000 patients and covers some sixty acres. The names of the various departments are seen on the plan.

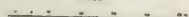
The pavilions are mostly one story in height. The surgical pavilions surround an operation house; and the medical, a bath house. The bathing establishment, to an American or Canadian visitor, is a marked feature. At the right of the main entrance is a large building devoted to mechanico-therapy. This is a department one misses in many large American and British hospitals. The Massachusetts General Hospital, with its fine Zander Institute, is a notable exception. Note the four receiving buildings for both sexes—medical and surgical. See the disinfection house. This is a provision in which the continental hospitals excel. Beyond the medical and surgical pavilions, the tuberculosis pavilions are to be noted, and, beyond them, the contagious diseases buildings. To the extreme left notice the barracks for leprosy, plague, and for other diseases which may become epidemic.

To the right of these are the buildings for power, laundry, and kitchen. In the upper right hand corner is the pathological building, and in the lower left hand corner that for diseases of the eye. Also note the building provided for alcoholic cases, and another building for diseases of the brain. Many continental hospitals have a pavilion for this class of case. Isn't it about time we began to realize that, under one administration patients suffering from acute brain disease, may be treated as well as those suffering with pneumonia, septicæmia, and other toxic diseases? In the upper left note the gynæcological division; also the building for animals required for experimental work. These are only a few of the features of this great hospital. It resembles the Virchow in Berlin very much. We were struck amusedly with the scarred visages and scalps of the resident physi-



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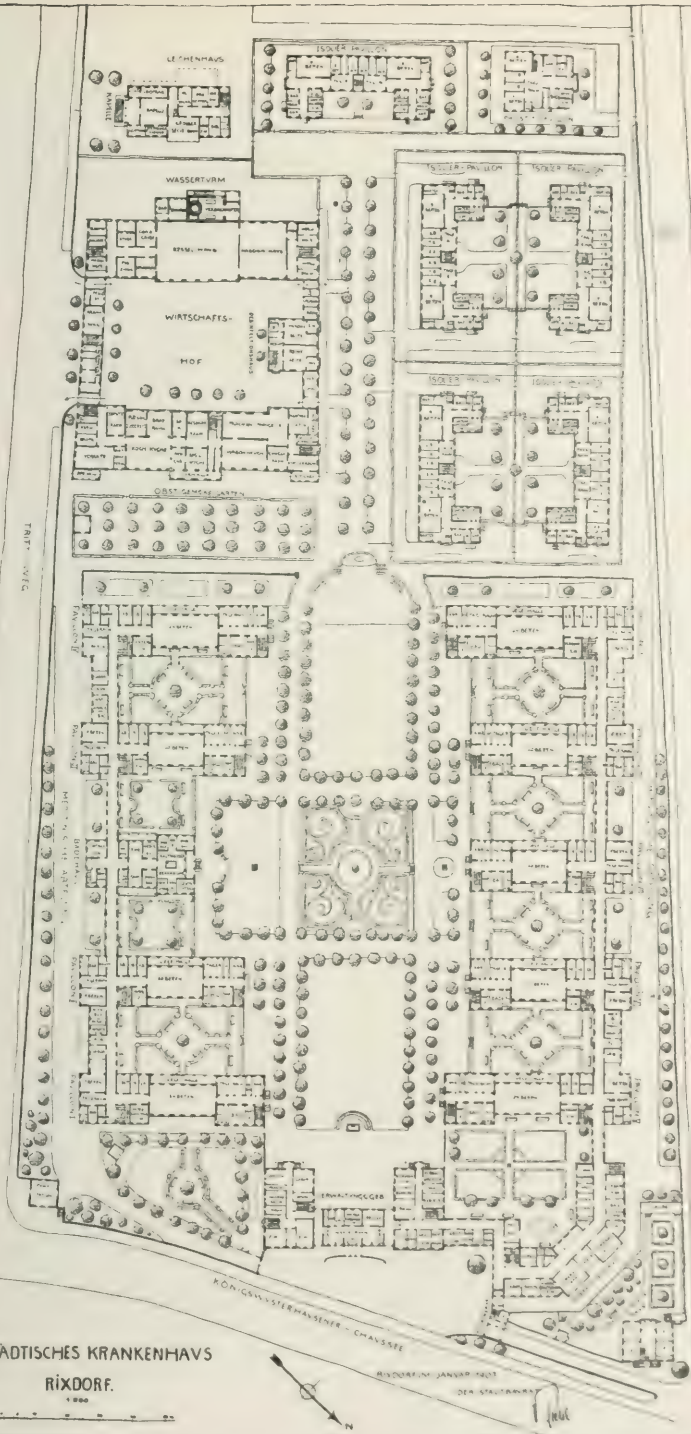
KÖNIGSGLÜSTERHAUSENER - CHAUSSEE

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cians, from the chief down. Some of them wore their hair clipped to the skin, in order (apparently) to show their honorable scars. It was whispered to us that German students often used caustics to prevent healing by first intention, and that the number of scars measured the amount of appreciation in which they were held by the fairer sex.

The Rixdorf Hospital is a run of an hour into the country from the centre of Berlin. The plan is worth study—a reading glass may be needed. Note that the groups of buildings are arranged round a central court, and that the members of the groups are separated by lawns, gardens and trees. The arrangement in the ward unit is rather unique. Note the arrangement around a court of the kitchen, laundry and power house—beyond the vegetable garden.

King's College Hospital, London, now under construction, will be one of the most modern hospitals in Great Britain when completed. The out-patient department, the casualty department, and the bath house (which includes the admitting department), are about completed, and some of the ward buildings are well under way.

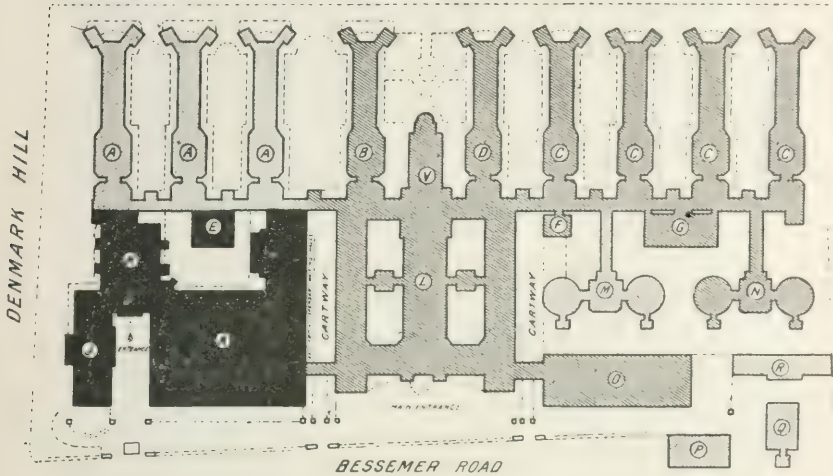
The first thing pointed out to me was a place for "prams" (perambulators). "This," said my guide, "was an afterthought. It is placed under a sort of bridge like entrance to the casualty department, and occupies a space about 12 by 15 feet.

Between the out-patient and the casualty department is a covered shelter, roofed in with translucent glass, where patients who wish may remain while waiting for attendance.

The main entrance to the out-patient department is by two doors some fourteen feet apart. By one door the men are admitted; by the other, the women. There is another entrance for children; and still another for children suffering from whooping cough. These pertussis cases have a separate waiting room and a separate examining room.

### KING'S COLLEGE HOSPITAL BLOCK PLAN.

- |                                      |   |                                   |
|--------------------------------------|---|-----------------------------------|
| A Medical Ward Block (Two Floors).   | G Three Operating and one Clinical Theatre. | M & N Special Wards. [Dept.       |
| B " " (Three Floors).                | H Bathing Establishment.                    | O Medical School and Pathological |
| C Surgical Ward Block (Two Floors).  | J Casualty Department.                      | P Mortuary.                       |
| D " " (Three Floors).                | K Out-Patient Department.                   | Q Isolation Block.                |
| E Clinical Theatre.                  | L Administration Block.                     | R " " Administn.                  |
| F Gyn. Op. PM. and Clinical Theatre. |   | V Chapel.                         |



Between the two corridors by which adult patients enter there is a good-sized room which is occupied by the porter and the admitting clerk. On the opposite side of each corridor is a toilet room. These corridors lead into a large reception room, beyond which is the great main waiting hall 90 feet in length by 43 feet in width. The height is 35 feet, I should guess. Running all round this commodious room and well lighted is a low arched corridor, connected with the main waiting room by three entrances on each side. On the opposite side of this low arched corridor are many doors leading to the medical surgical, gynaecological and other divisions, the rooms of which are ample, light and well provided with wash basins.

A buffet will be provided in the centre of the main waiting hall, and a separate tea room is provided with scullery adjoining. The walls of this room are of terra cotta, the

surface of each brick being about 9 by 14 inches. The walls of the examining rooms are plastered with a granitic silicon.

The out-patient building is heated by steam. The radiators are hinged and swing out from the wall. Below them the fresh air enters, passes over the surface of the radiator and is distributed through the room. Just above each radiator is another large opening for the admission of cold fresh air. This, like the place for the "prams" was an after-thought. It was the original intention to sink the radiators into the air shaft below them; but this idea was abandoned. The foul air is drawn out from three openings along the centre of the arched roof, by means of large fans operated by electric motors.

The pipes for gas, electricity, etc., run in shallow air-tight metallic trenches; these trenches are about 14 inches wide and about 10 inches deep. They are covered with the same material as the floor. One sees along their course two metal strips only, corresponding to the edges of the trenches.

The bath house contains the admitting department. Here one enters the admitting room first and sees adjoining a room for patients' clothes. Passing into the corridor one sees on either side a series of bathrooms—one series for male patients, the other for females. The floors are laid with a fall to a small open tile trench. The wall brick are of the Kent's stock variety, and contains so much shale oil that they require dovetailing in order to hold the plaster. The dado is made of Bickell's patent cement. The doctors objected to tile being used on account of the numerous seams. One bathroom of each series will contain tubs for continuous baths; another will be used for vapor baths, another for CO<sub>2</sub> baths, and so on. The partitions are built of narrow tiled brick laid on edge and framed with ironwork. They do not extend to the ceiling or the floor. Passing through an air cut-off one enters a suite of two rooms in

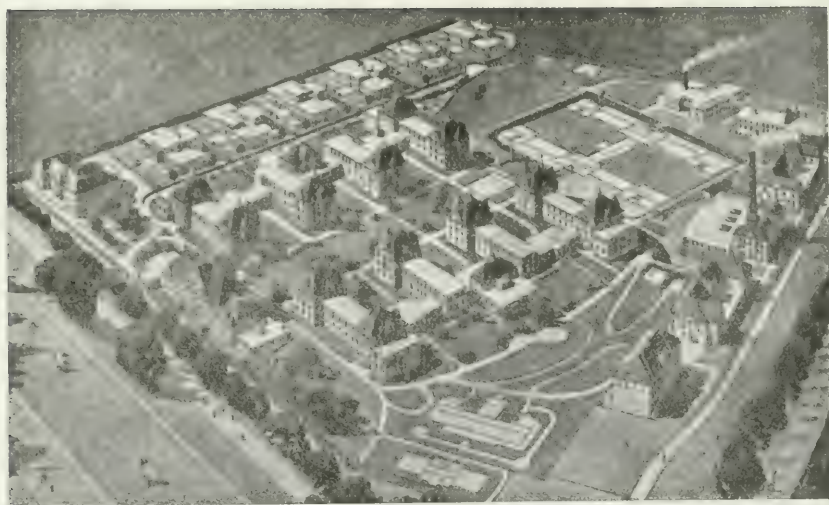
which sulphur baths are to be administered. In rooms nearby, provided with cubicles, the X-Ray and electric apparatus are installed. The partitions between these cubicles are built of a double row of these narrow tile brick on edge with a sheet of 5-lb. lead between. These partitions reach the floor. Adjoining is the photographic department, its rooms being provided with light-tight shutters. The walls of the developing rooms are of ruby tile. Adequate provision is made for mechanico-therapy. The gymnasium is 24 feet long and 22 feet wide. Near the main entrance is a padded room for the temporary reception of delirium tremens cases.

The casualty department is built on the double corridor plan, and will provide for eight patients, four on each side of the corridor, each having a single room. The partitions on each side of the corridor are of wood from the floor to a height of three and a half feet; above this they are of glass. This will enable the nurses to watch the patients from the corridor.

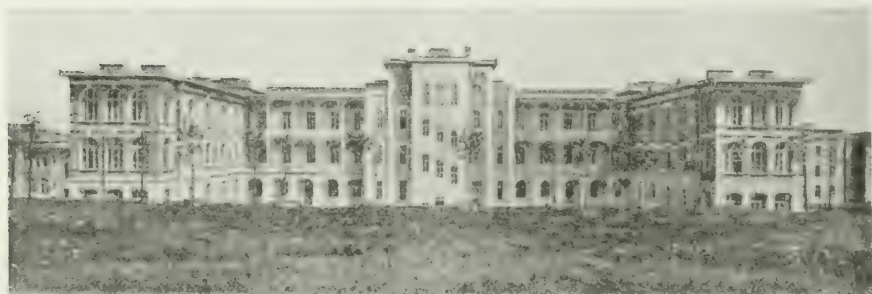
The new Charlottenburg Hospital in Charlottenburg (a portion of Greater Berlin, like Rixdorf) is another delightful place. This birdseye view shows to the left (the long side being near the spectator) the administration building. Behind it is a row of medical and a row of surgical buildings; the pavilions of each department are connected by corridors. The surgical row has its operation house and the medical its bath house, each of which may be seen. Note also the small examining building connected with the corridors. The buildings for contagious diseases stand to the extreme right, while to the left are the kitchen, laundry and the heating, lighting, and power plant.

The next picture is a view and ground plan sketch of a new 400-bed hospital for Vienna sick nurses at Lainz. Near this main building is an isolation house of 36 beds, and also an observation barrack with 4 beds. It is well-lighted and well provided with airing balconies. The surroundings are beautiful, being situated near the Thiergarten.





Charlottenburg West-End Hospital



Nurses Hospital at Lainz





Frauenklinik, Dresden

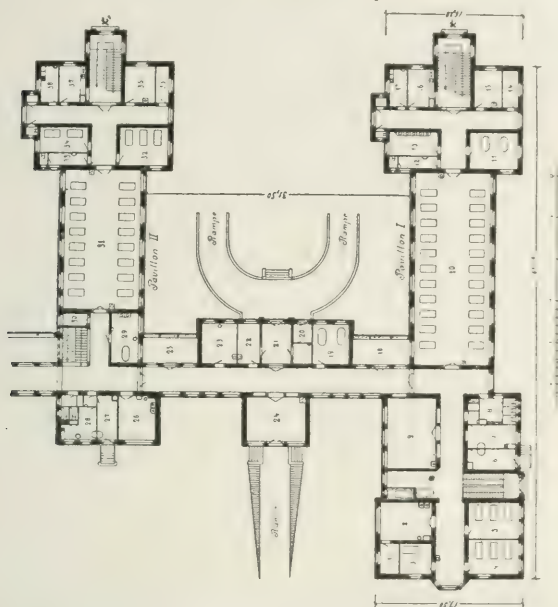
These are two views of the new Frauenklinik at Dresden. Provision is made for septic cases in a separate pavilion. I was greatly impressed with the privileges accorded here to young doctors desiring post-graduate work in gynæcology and obstetrics. The course is five months and costs, including tuition and board in the hospital \$3.50 per week.



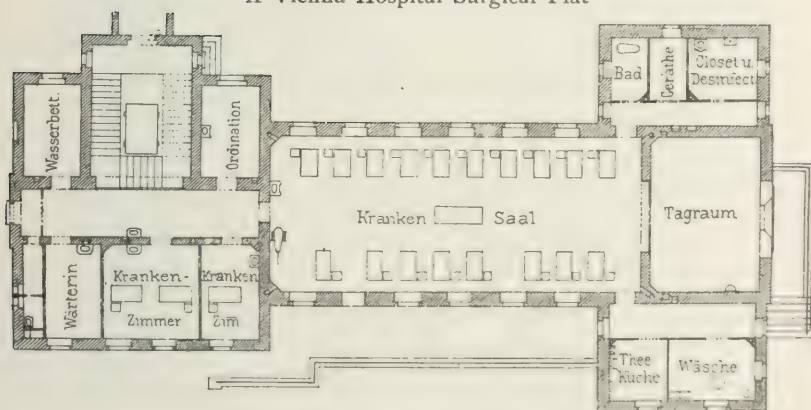
Frauenklinik, Dresden



whence it is placed in the receptacle and after sterilization withdrawn into the clean room, No. 7.

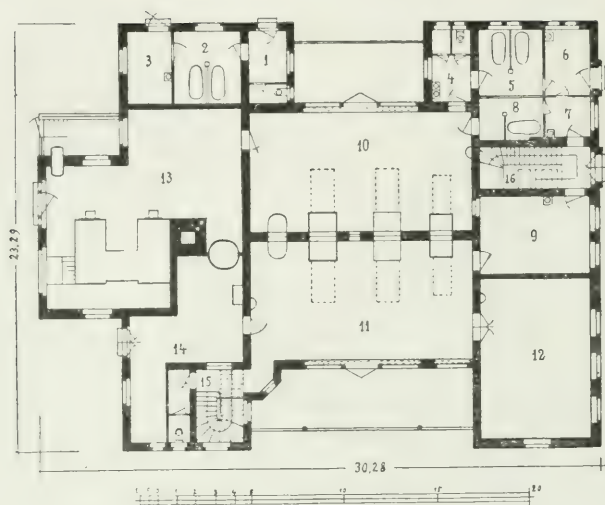


A Vienna Hospital Surgical Flat



Vienna Ward Unit

This is a typical ward unit in one of the new Vienna hospitals.



A Disinfection House

This is a picture of one flat of a disinfection house, which also contains an incinerating plant. In room 1 the patients discharged from the contagious pavilions are received, disrobed, passed into room No. 2, bathed, admitted to No. 3, given clean clothing and allowed to go home. Rooms 4, 5, and 6 show a similar suite for the disinfection house employes; 7 and 8 provides for the officers. Room 10 receives the infected mattresses, other bedding, etc., requiring disinfection. They are then placed in the large sterilizers intersecting the wall, subjected to steam pressure and formaldehyde; and when sterilized withdrawn into room No. 11, and stored in No. 12 until required. All infected material needing to be destroyed is taken into room No. 13 and incinerated in one of the two Kori ovens. The left-over infected food is sterilized in the small receptacle just to the left of the door entering room No. 13. The infected dishes and utensils are placed in the tank intersecting the wall between rooms Nos. 13 and 14. They are removed through room No. 14. Note the toilet room accommodation. This sort of building is needed in many hospitals on the American continent.



Lying-in Room



Babie's Washroom





These three pictures show respectively the labor room, the babies' bathing room, and the incubating room for premature babies in the new Frauenklinik, Dresden.



Corner of Section Room, St. Georg

This shows a corner of one of the finest pathological section rooms on the continent—very well appointed and kept with scrupulous care. Note the elbow valves and read

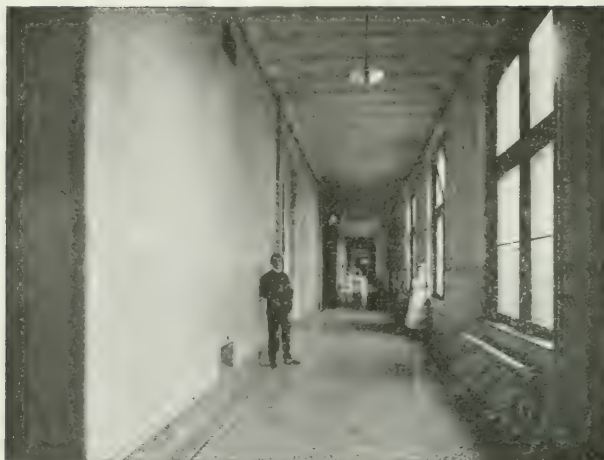


Mr. Stevens' description of the fittings. The presiding genius is Prof. Simmonds who was very kind to the Canadian who addressed him in very bad German, replying to him in perfect English.



Wax Room, Dresden, Frauenklinik

This shows a room containing specimens in wax. Generally found in the departments of skin and venereal diseases. The form, color and general appearance of the lesions are well represented—the various syphilides, smallpox, leprosy, etc., etc. St. Georg, Hamburg, has thousands of specimens. America should import some of the modellers of these wax specimens.



Corridor

One is struck with the amount of corridor space in any of the continental hospitals, as compared with the amount seen in the hospitals of Britain or North America.



Ward Interior, "St. Bart's"

Here is a "homey" old ward in St. Bartholomew's Hospital, London. Note the flowers, the pictures, the rug, and the open grate. Though you cannot see the fire, it is there.

In addition to the above, Dr. Brown showed the following pictures: An outside view of the Royal Infirmary, Manchester, England; one of its typical wards and operating suite; a story showing one long and one rectangular ward; and an interior ward view. A general plan of the wards of the Royal Victoria Hospital, Montreal; a view of a portion of the Eppendorf at Hamburg; one of its typical wards (interior), and a pavilion plan. A ward plan of the Derbyshire Royal Infirmary, England, England. A ward plan of one of the Johns Hopkins pavilions, Baltimore. First floor plan of the new hospital, Albany, N.Y. Ward plan of a double surgical pavilion, Dresden. Ward plan of the new City Hospital, Muelhausen. Plan of double pavilion, Virchow Hospital, Berlin. An interior of a Virchow ward. Plan of ward unit New Hospital, Nuremberg, Germany. General plan of wards of the University Hospital, London, England. Plan of ward unit of the new Scarlet Fever Hospital, Philadelphia. Ward plan of the Pasteur Hospital, Paris. Interior of ward of new Burnham pavilion of the Boston City Hospital.

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## DETAILS AND EQUIPMENT OF THE HOSPITAL.

BY EDWARD F. STEVENS, A.A.I.A., BOSTON.

It was with some hesitation that I accepted the appointment of the Committee on Hospital Construction which has always been filled by a hospital superintendent of prominence and of larger experience.

I have read over the reports of the last three years, as well as the reports of other papers on hospital planning and construction which have been given to this Association, and I find that the field has been pretty well covered from every point. It may be that the writer of one paper has insisted that no ward should be larger than six beds, while another states that a twenty-bed ward is the best to administer; that one thinks the utilities should be placed in a corner toilet tower, while another believes these utilities should be placed in a less prominent position. In studying these problems of hospital planning with many superintendents in all parts of the world, I am led to believe that what may be perfect and complete in Northern Canada would be simply ridiculous in Florida; that what would be complete in Germany would be lacking in detail in America: and I believe that the planning of the hospital is unlike the planning of any other building, for it must be developed for the climate and the environment in which it is to be built, and no rules can be laid down which would apply equally well to all parts of the country.

So, with the advice and consent of your President, I shall not discuss at this time the construction and planning of the hospital, but shall take for the subject of the Committee's report the "Details and Equipment of the Hospital"—comparing the American with the European work, and, in taking this branch of the subject, I will not be trespassing so much on the field already covered by my predecessors.

As Dr. Brown has already told you, we inspected many of the best hospitals in Holland, Germany and Austria, to-

gether, and consulted with the best authorities, both doctors and architects. His report has taken much of the wind out of my sails, still, where he carried the note-book I carried the camera, so you can consider him my advance agent, and I will *show* you the real things he has been talking about.

I think it was our own Dr. Emerson who said—in a paper presented a few years ago to this Association: "A hospital building is a piece of medical apparatus for use in the treatment of patients." If that is true about the hospital building, is it not more true about the interior details, the equipment and furnishing of the hospital?

By showing you on the curtain some of the things which I was able to photograph myself, or to secure from other sources, it will give you some idea of the way other hospital men in other countries as well as this have solved some of their problems.

#### CONSTRUCTION.

The interior finish and details of a hospital are of a good deal of importance when the economic and hygienic side is considered, whether finish is to project with edges and mouldings to catch dust or to have a smooth surface. In the modern German hospital one rarely sees any projecting member (and I am speaking now of the portion of the hospital set apart for the care of the patients).

The door jamb may be of iron or wood, but it is sure to be of the simplest detail.

The iron jamb is quite likely to be continued through the wall and around the opening in tiles as is well illustrated in the private hospital of the "Merchant" in Vienna, or in the plain finish at the St. Georg's in Hamburg.

But while this finish above the floor in the foreign hospitals was well-nigh perfect, the joining to the floor in nearly every hospital which we visited in Europe was, to my mind, very bad, as it left an untidy angle impossible to clean.

(1) If this door jamb is cut away and the base carried through as is shown in the photo, which was taken in Grace Hospital at Detroit, it is almost impossible for any dirt to collect.



This base and jamb are set before plastering, so that every part of the finish is smooth with the wall.

This same character of finish should be applied to the windows.

The American door manufacturers certainly make better and more sanitary doors than in any country I have visited. The one panel or no-panel slab doors now being used in the modern American hospitals are to be desired above those used abroad.



## HARDWARE.

The hardware is a small item, but should be selected for its suitability. The angle door knob or handle as seen in the German hospitals has many advantages over the glass knob. Invisible hinges, boxed strikers, and non-projecting hardware can be used to advantage.

## FLOORS.

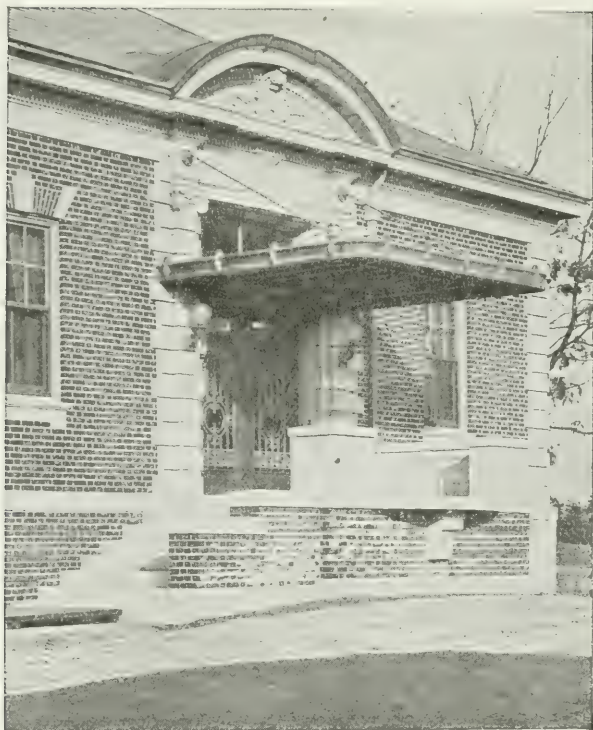
The ever-present question, "What is the best floor?" is often met with and is hard to answer. This question I asked of the leading architects and hospital men and the almost universal preference seemed to be for tile, a light grey pebble finish vitreous tile; the next favorite for a hard or dense floor was terrazzo, while one would see everywhere on the Continent the battleship linoleum. This, cemented as it was to the construction and laid against a tile base, made a very hygienic, noiseless floor. One would hardly ever see wood used for floors, while linoleum was used not only for floors, but for table tops, stair treads, screens and even for door panels. In my own practice I have found that linoleum is the best all-around ward or private room floor, because of its noiseless and sanitary qualities.

## EXTERIOR DETAILS.

The exterior details of the hospital are important, but should be made subservient to and expressive of the plan and to fulfill the mission of the hospital.

The entrance should be dignified and express its use as far as possible. The illustration shows a simple ambulance entrance at Brockton, Mass.

The prevailing idea of surgeons and physicians that the patients should be in the open air as much as possible, makes it necessary for us to design airing balconies and roof wards. The hospital at Utrecht, in Holland, had many excellent features, one of them being the extensive airing balconies.



Ambulance Entrance at Brockton, Mass.

These airing balconies are used very extensively wherever they are provided. The one at Beverly, Mass., looks out on a most charming pastoral landscape. The roof wards are used extensively in this country. Provision should be made in these roof wards for diet kitchen and toilets, the same as for regular wards, so that the patients could be cared for night and day if necessary.

The airing balcony cannot, however, always be in the sun, and the clever director of the Urecht Hospital has had a revolving balcony built, which follows the sun or can be placed to shield the patient from the wind. (Please notice that your Secretary is taking the treatment).



Utrecht Hospital in Holland



Revolving Balcony, Utrecht Hospital

The solarium is, of course, useful as a day room, but unless well ventilated is apt to get pretty stuffy. They can be made attractive with palms and flowers. (The illustration is of the Corey Hill Hospital).

#### WARDS.

Why not make the whole ward a solarium? as was done at the Beverly Hospital? The windows made large, extending low enough so that the patient could look out



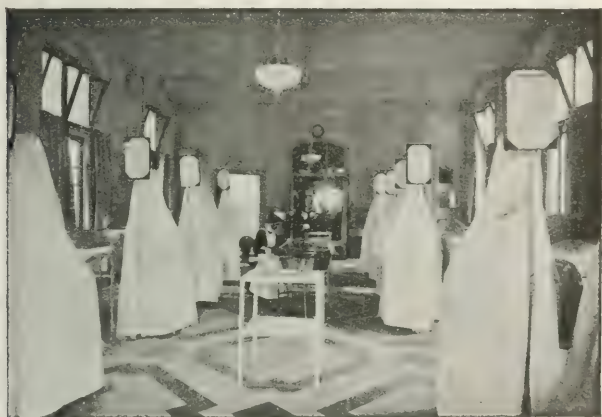
while lying in bed, and high enough to secure the maximum



of sunlight. In the European hospitals casement windows are used, as well as transoms, but one hardly ever sees the unsanitary roll shades. The washable linen curtains are used and make the ward much more homelike.

Artificial lighting for the general illumination of the ward using a reflecting light is much less trying for the patients than where the light is direct.

Note that in this ward the patients, except for the outside bed, would have little or no sun while with this (the Heywood Hospital at Gardner) the ward is flooded with sunshine.



In the German and Holland maternity hospitals the babies are always kept in the same room with the mothers and the draping of the bassinets is sometimes quite grotesque. This hospital at Utrecht was one of the best equipped that we saw. (Note here again the reflected light). The equipment of the wards and private rooms is essential and the beds form the most important part. The spring and mattress should be comfortable and well made. The spring and mattress should be comfortable, well made. The bed should be made easy of adjustment for fractures, which can best be done with extension legs. The head, if made with horizontal bars instead of vertical, affords much comfort to the convalescent, as by these bars one is able to lift one's self more or less. (Note here, in this slide, the bed-



side lamp which can be attached to the wall or put upon the table. I consider these adjustable lights more serviceable than a fixed side light).



The bed should be adjustable. One of the best arrangements I have seen was in the Western Infirmary in Glasgow. By pressing the lever at the foot of the bed, it at once became ready for moving into any other part of the ward or on the roof, if necessary. When the lever is raised, it at once becomes firm on the floor.

We saw a great variety of maternity beds, but none were more practical than this. For normal delivery it is a straight, full length bed. When the use of instruments is necessary, the bed can be separated in the centre, without moving the patient.





The washing of the baby is attended to with much precision in many of the foreign hospitals which we visited. In one there was a little glass case for the toilet articles for each child, placed on the wall over the bassinet. In others the babies were washed on a slab, with a spray. A large tank, as shown in the picture, is filled with water at the right temperature and the child is sprayed instead of being tubbed. This is at the Wilhelmina Hospital at Vienna.

The Presbyterian Hospital here in New York uses a similar device for washing, with room for two babies.

This system has been adopted at the New Children's Building at the Johns Hopkins.



Mr. Butler has used here the glazed dividing partitions for the rooms in the isolating department, similar to that seen in the Pasteur at Paris.

The observation ward of this institution has the unique feature of having in the same room children infected with different diseases, for observation purposes, dividing the cases only by a glass partition some eight or nine feet high. Scrup-up bowls occur along the outside wall. There

is a free circulation of air everywhere, and why is this not a simple solution of a small contagious hospital? Perhaps the cubicles, like the Pasteur, where the room is absolutely cut off from another, would be a little safer; but I believe that for the small contagious hospital, there is no necessity for separate buildings for the different diseases and with proper isolation of the building and precaution being taken by everyone visiting and the observance of the laws of antiseptis, these cases should be as safely cared for without danger from cross infection as in separate buildings.

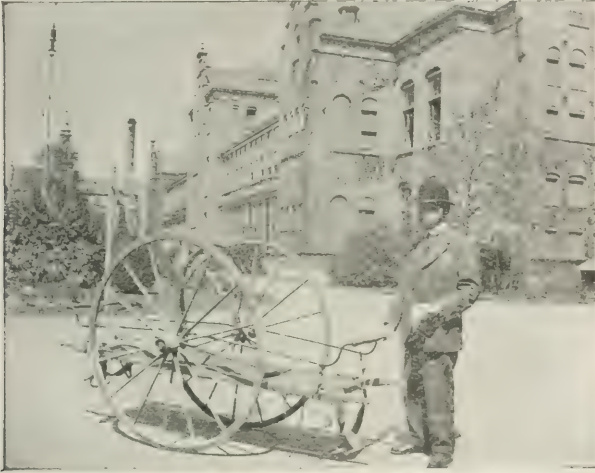


Of course all utensils, china, and everything about the patients should be sterilized and in this way there would be no necessity for keeping the china of the different cases separate.

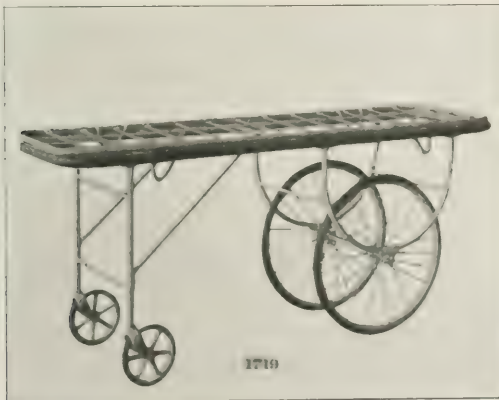
A simple and practical examination table for children is shown on this slide as well as an incubator used with greatest success in the Presbyterian Hospital here in New York.

In the larger European hospitals the buildings are isolated so that the service of ambulance and food must be had over the ground and the high wheel covered stretcher is seen everywhere.

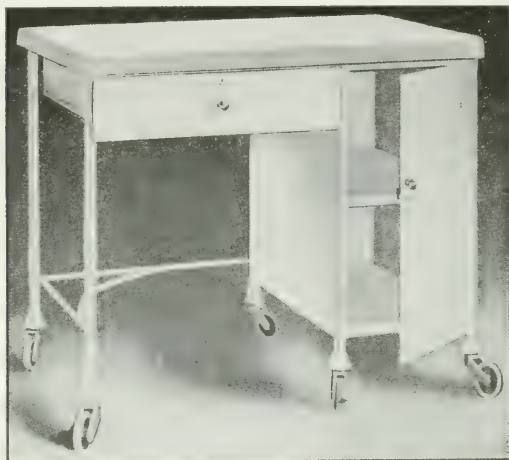
In Holland the tricycle stretcher or ambulance is a common sight on the street near the hospitals, while in other sections the low stretcher is used. (They may not always be able to secure as intelligent an orderly as I did for this photograph).



But with our American corridor system the lighter rubber-tire stretcher is used; if these are bound with rubber tubing, much of the knocking of the wood and walls is avoided.



Wherever the headquarters of the ward nurse may be, whether in the chart room, the corridor or the ward itself, there should be every convenience for the keeping of records



and making notes. A nurse's desk, preferably of steel with clear glass top, where everything is in sight and must be kept neat, is here shown, or the more substantial porcelain enamel top is preferred by some. We found that the method of keeping of charts and notes varied with nearly every hospital we visited. In some cases these charts, etc., were kept in folio form piled on the desk, in others they were on the bed itself, generally when the visiting surgeon was making his rounds he was followed by the head nurse with her arms full of charts and notes and the proper folio was handed him as the next patient was visited. In this country, however, one is quite apt to find charts, diet slips, diagnosis, etc., all hung at the head or foot of the bed very convenient for the nurse, to be sure also very convenient to every visitor to the patient, and, if the little zig-zag lines take a different course from day to day, it is apt to create suspicion in the minds of the friends as well as the patient.

I strongly believe that these charts and other data about the patient should be kept at the nurses' station where with a simple cardboard holder and all sheets of standard size, all records, doctor's orders and diet slips can be bound together, and, when the visiting physician is making his rounds he sees at a glance the entire history of the case. These holders can be arranged in a cabinet like the one shown—when open all are exposed and when closed nothing is visible.

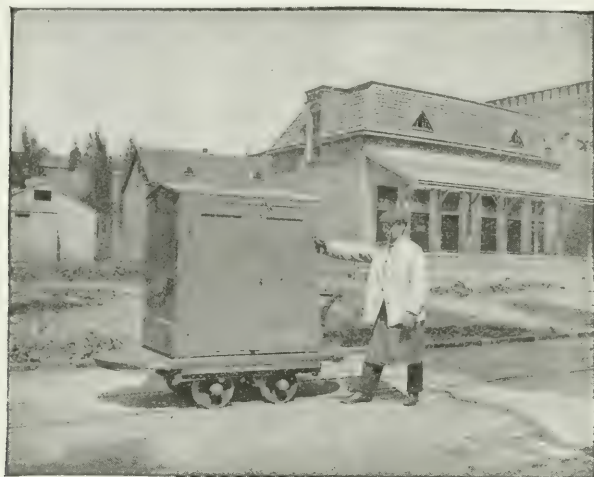
On the Continent one sees very few nurses' bedside calls—either bells or otherwise. The patient must wait until the nurse makes her rounds; in an American hospital, however, nurses' calls from the patient's bed seem a necessity.

I cannot recommend too strongly the doing away with the noisy clamor of the ordinary calling system for the nurse and doctor. I think the bell system should be relegated to the shop and factory where noise is expected as noise, begets noise, and no matter how many "silence" signs there are, if the electric call bell is going whenever a patient wants to turn in bed, there will be other noises to drown that. With the simple devices of electric light calls, now on the market, the working of which is simpler than the electric bell itself, I think that the system, however simple, should be so arranged that the patient after once pressing the button could not cancel the call, and, at the same time, the nurse should only have to go to the patient and not to the wall behind the bed to cancel it. A system of this nature has just been installed in the Grace Hospital at Detroit. A similar system for calling the internes was also installed, the signals are set from the main office and by different colors and positions of electric bulbs the different doctors are signalled to answer, they go to the nearest house 'phone and call the office for instructions, then the call is cancelled.

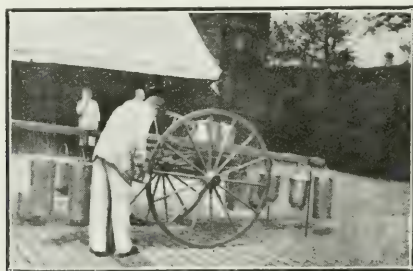
The carrying of food from kitchen to patients is a very important item in hospital economics. In the great Steinhof



at Vienna, where three thousand patients are scattered over acres of land, the food is carried in electric cars and in an incredibly short time is in the various serving rooms.

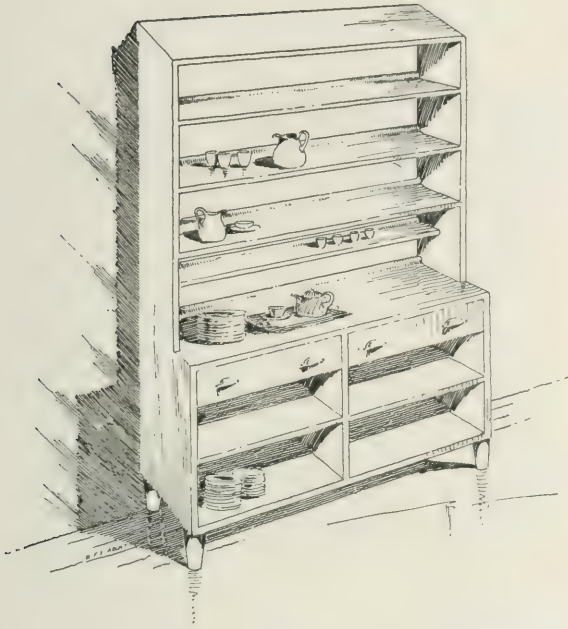


In the smaller hospitals, push cars are used. At Utrecht this was a heated car, while in some of the German hospitals the two-wheel cart with cans hung upon the high rails were used, while the simple open carrier is sufficient for short distances.



I believe that a food carrier made on the principle of the fireless cooker should be used for long-distance transportation.





In the diet kitchen or serving room, everything should be provided for serving the food warm and palatable. The steam table and hot plates, the gas stove for occasional light cooking, the tray rack for the laying of trays, the cabinets for the ward china. These cases I believe should be so made as to prevent any vermin from collecting, set away from the wall with open shelves and no back; with a slanting top where the dust, if any, can be seen and removed.

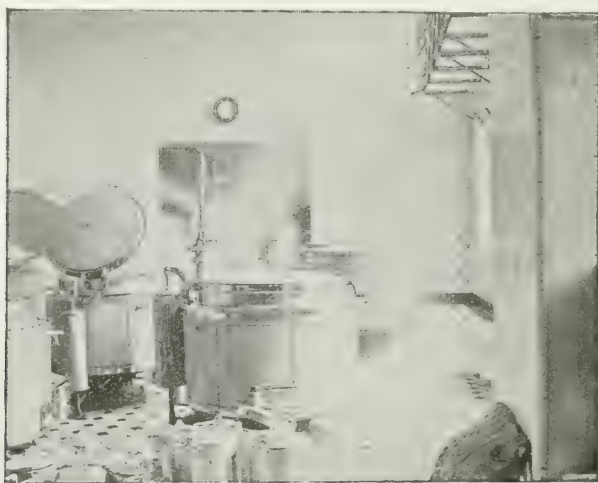
The diet kitchens in the German hospitals are used much as we use them. The food closets in the Western Infirmary at Glasgow were made on the outside wall with openings to the outer air.

In some of the contagious hospitals I visited, the food was brought to a receptacle in the outer wall and removed from an opening in the inside by the attendant, then the

soiled dishes were put back and live steam turned on before they were removed, forming a sterilizer out of the receptacle.



The details of many of the kitchens in the German and Holland hospitals were sumptuous and splendidly worked



out. That of the Women's Hospital at Utrecht had the walls and ceilings tiled, the cooking done mostly with gas, the fixtures away from the wall everywhere.

The St. Georg kitchen, much larger to be sure, was just as carefully worked out in every detail the great ranges with their special covers, the soup and stock kettles, all in white with balanced covers.

The several and smaller vegetable cookers.

The bread and pastry ovens all immaculate, made the preparations of food good to look upon at least.

Even the small hospital can have the essential elements,—the range clear from the wall, the dressers for supplies made of metal and slate, the cook's table made in simple design.

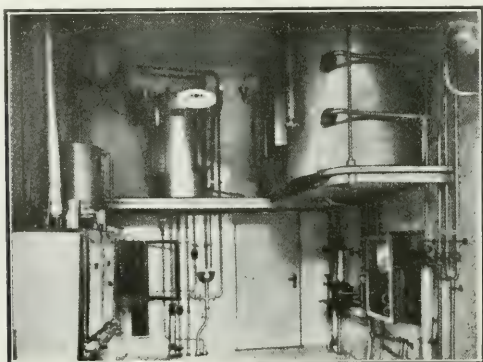
The equipment of the sink room is growing in importance with every new hospital. Less is made of this room in the European hospitals than with our own. The sink room becomes the work room, the laboratory, the repository for all dirty ward work. In this room there should be the sterilizers for stools and bed pans; also the ward incinerator (and this I consider almost a necessity in the modern hospital), the sinks, the blanket warmers, the bed-pan warmers, the mops and brooms for cleaning are all essential, etc. This room should have large doors, and, above all things, should be well ventilated, lighted and heated. While the time will not allow me to take up disinfecting rooms and sterilizers, I just want to show you one of the best mattress sterilizers I have seen in this country or any other, either for wet, dry or chemical sterilizing and disinfecting.

It was a very noticeable fact that even in the large German hospitals there were but few operating rooms as compared with the number of patients. Even in the great Viehhof there were but four. In the St. Georg Hospital

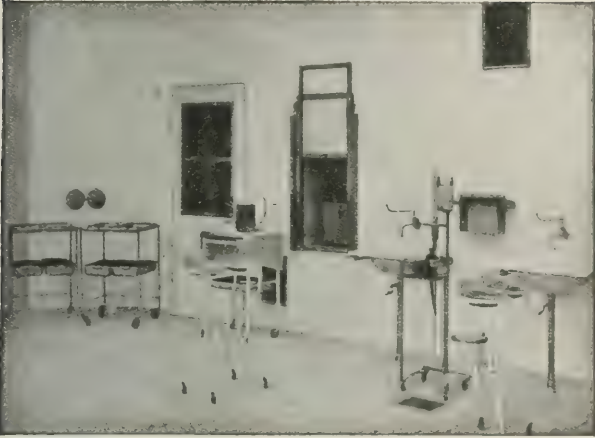
there are but two—a clean and a septic. In the clean operating room the walls on two sides and ceiling are of glass and double with spaces between for heating, and the heating of these rooms I will tell you about in a few minutes.



The sterilizing room is placed between the septic and clean rooms entering from the clean and from the corridor, there are windows, however, which you will note in later slides, and, at these windows are the instrument sterilizers, which can be reached without leaving the operating rooms.



The anesthetic room also joins this room.



The artificial lighting in the operating rooms is accomplished by means of three dome shaped ceiling fixtures with numerous high candle power lamps.

The opposite side of the room shows the windows to the sterilizers, the solution holders, the steril and salt solution taps. The furniture is much the same as you would see in most operating rooms.



As a contrast to the plan of St. George's operating building, with its two operating rooms may I show you your President's new operating floor at Detroit; here we have four operating rooms beside an eye and ear surgical dressing and plaster rooms. In order to avoid contact with a surgeon just coming in from the street, the scrub-up room is placed inside the operating corridor with no connection with the locker room. The students enter the theatre from an outside stair-case and no connection is made between the students part and the operating pit. There is provided a large room for the nurses and for the sterilizers, a blanket warmer (almost a necessity), an instrument room and supply room are provided.





For lighting of operating rooms, single large reflectors were used in many of the rooms in the German hospitals.

The crane light was often used; this at Urecht is in the theatre, the crane light we find in many of the English hospitals.

I have used this type of fixture with good success. This shows a crane swinging to the centre of an eighteen-foot room, this fixture at the Beverly Hospital has the advantage of being swung back out of the way and leaves no dust-retaining surfaces above the operating table. This can be raised or lowered at will.

We found that the reflected light from a high power arc lamp in an adjoining room shining through an opening in the wall reflected from one mirror to another, and thence to the seat of operation was very successful.

In the Rudolfener Hospital at Vienna the operating rooms were placed side by side, having clear glass partitions about eight feet. Here the sterilizers were placed in each operating room, the artificial lighting was above the glass ceiling.

I believe the day of the large ampitheatre for major operations is over and the smaller rooms with movable observation stands where the student or observer can get near the patient, should take its place. This picture shows a room in the Douglass Operating Building at Brockton, but the stand is the Massachusetts General Hospital type, which, I think, is the most compact and serviceable I have ever seen on this continent or the other.

This soiled linen bag which we saw at Georg's—arranged to close like a wallet, and when placed on the frame which it neatly fits, makes a most attractive and useful adjunct to the operating room furniture.

The operating table has almost as many styles as a season's stock of ladies' hats, but I will show you two that particularly attracted my attention. The first for its quickness of action from one position to another, and the second, with its many adjustments, seemed to be a very popular table in European hospitals, and is occasionally seen in America.



Of the many adjuncts which go to make up a complete equipment of the operating room, might be mentioned the instrument tables, the solution holders, the dressing cans, with pedal attachments, access to the instrument sterilizers and to steril water.

The solution holder shown here was taken in St. Georg, also. These are used instead of the usual solution basins which are often used by more than one person.

The equipment of the sterilizing room may be as varied as the room. To my mind, this room should be large and well ventilated—placed near the large operating room.

At St. Georg's the main sterilizers for water and saline solution were placed at an elevation so that they could be used from both rooms. In the basin every valve and every pipe is clearly marked and is very complete.

At the Sophien Hospital, at Vienna, the sterilizers were all in a recess between the sterilizing room and the

major operating room. The pan sterilizer was on an open truck which was placed in the enclosure over the gas jet, and when wanted drawn out into the operating room. The dressing sterilizers are the vertical steam-boiler type, and the cover is hoisted when wanted. The instrument sterilizer is in the centre.

The arrangement at the Vienna General Hospital is very similar.

At Utrecht, the high wall tanks were used. At Rixdorf, the sterilizers were most complete, being entirely heated by electricity, and I regret not having a photo of that room.

In America one is quite likely to see the sterilizers placed low, but in a separate room. This shows a small sterilizing plant in a fifty-bed hospital with water still and salt solution tank (and I believe the water still should be considered carefully in fitting up a new hospital).

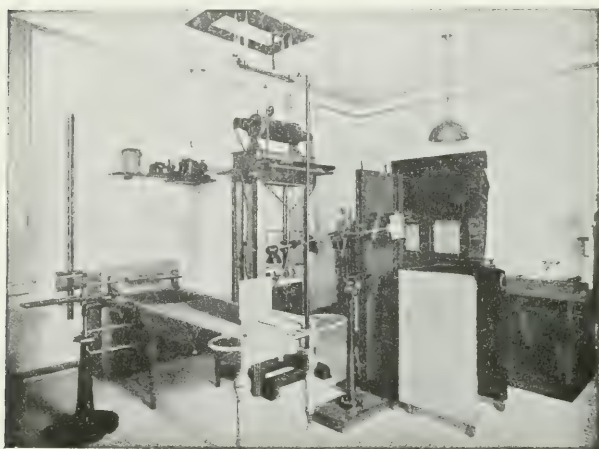
With modern methods of assembling, everything in the factory, the erection of a sterilizing plant becomes easy.

No hospital nowadays is quite complete without its Röntgen or X-Ray room and apparatus. The styles and sizes of the apparatus and character of the work done varies with the institution. The Röntgen Institute, as this department is called in the German hospitals is made much of—occupying in the case of St. Georg's the entire second-story of the operating building.

The photo shows the X-Ray with special apparatus for examining the chest. The tube is enclosed in a lead box with opening only against the patient. The action of the lungs is shown on the plate held by the patient. We saw such an apparatus at the Virchow in use.

For photographing the patient for kidney or other trouble in that region this apparatus is used. In the description in Dr. Deneke's book he speaks of a water cooler used

at the base of the instrument. Authorities seem to differ as to the amount of protection needed for the operator, some maintaining that safety is only had when the operator is protected, not only from the direct, but the indirect rays, and, that all metal in the room becomes radio active with the entire current of a modern X-Ray machine—while



others claim that with the new powerful machine where the image is made in the fraction of a second that no special protection is needed. When doctors disagree it is time for the laymen to step down.

Occupying a position of equal importance with the operating department in the German hospitals is the bath house. This building, occupying the same relative position on the medical side that the operating building does on the surgical. In this building are located the various baths as you will see by the plan, with its electric, steam, sand, duche, brine, CO<sup>2</sup> (carbon dioxide), hydro-electric, etc. This only shows the plan of one story.

The sand bath is, perhaps, the most complicated, as the sand after use must be sterilized and heated to the de-

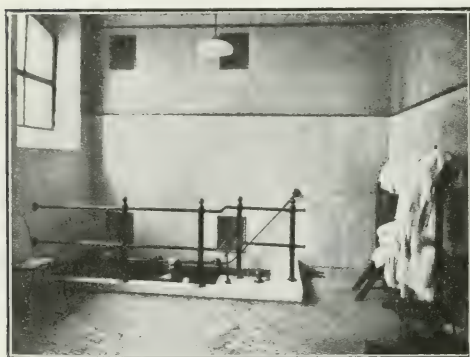


sired temperature, a device like a grain elevator is used to raise the sand to the sterilizers.

The hydro-electric bath tub must be of wood or some non-conducting material.



The plunge bath one sees in nearly all large hospitals and sanatoria.



The Turkish and steam baths are also found in many hospitals.

But the water bed in one form or another is often seen even in the open wards.

A portable tub, however, can be brought into requisition for emergencies.

The sun bath is provided in many sanatoria, and has much to commend it.

I thoroughly believe that we in America should do more for the medical side of our staff in the way of special rooms and equipment for baths, muscular development and exercises for various forms, it is not uncommon on the Continent to see a well-equipped gymnasium and mechanical massage room in the hospital.

In the Pathological Laboratory some of the best work of the hospital is done and I urge suitable quarters for this important development. The plan shows the building devoted to this at St. Georg.

The dissecting room was large, well-lighted and well-ventilated with tile floor and wall, and one of the best dissecting tables I have seen. This table—made of marble with its centre higher than the side with a gutter at the side draining to the sink at the end—water supply was through hose at the centre of the table and the instrument table at the



foot. Our attention was called to the use of all blunt pointed instruments instead of sharp pointed.

The laboratory itself in this hospital was very much up-to-date, the tables were movable with white glass tops with the exception of two spots about four inches square on each table which were black.

As I have shown you so many views of St. George, I know you will be interested in the method of sterilizing and tempering the air used in the operating room.

In the section shown through the major operating room you will notice that the outer sash is double and air is conducted entirely around this hollow space—warming in winter and cooling in summer, the floor, the walls and the ceiling, additional heat in winter is secured from direct radiators behind thin nickle plates shown in the walls, but allowing no air from this source to enter the room. The air for the operating rooms is first brought into a clean chamber where it is passed through ground coke, thence over heated coils in winter, and ice in summer, through into the fan shown here where it is driven through a filtering substance of fine sand and gravel and thence taken to the operating rooms, practically free from all bacteria, the cooling vents in the operating rooms are closed and there is a sufficient pressure outward so that the opening of any door would not admit foul air. This may have been carried to a refinement beyond which it would be unnecessary to follow, but it certainly was a well developed plan.

While it is not my intention to go into the subject of heating and ventilation of hospitals, as that is too broad a subject to take up here at this time, still I want to show you a few simple ways which have been called to my attention.

At the Franz Joseph Hospital at Vienna a combination is used for mixing the hot and cold air. Either the air comes from ducts below—passing over the radiators, or, by manipulating the valves, the air of the rooms is circulated.

I noticed in the new General Hospital at Vienna that this method was used pretty nearly everywhere—introducing the fresh air from outside at the top of the direct radiator depending on the natural tendency for cold air to drop.

This problem of a simple form of efficient heating and at the same time introducing fresh air, I have worked out in several hospitals, that is, by having the air brought in directly behind the radiator and a removable shield making the cleaning a practical problem. The patient is supplied with sufficient air direct from out of doors with the room suitably ventilated, the ward flushed out with fresh, pure air, without interfering with any mechanical systems and just now let me say that I am for simple forms of heating and ventilation for hospitals, for, who wants to breathe air at a certain even temperature all day, the patient in bed covered with blankets does not need the temperature at 70 degrees or 75 degrees, and is not comfortable with it.

My old professor of ventilation used to say the ideal temperature was that of a beautiful June day in a pine forest in New England, but, this would not be at just 65 degrees or 68 degrees for the twelve hours. It would be varied with movements of the air.

A system should be used which would be as near "fool" proof as possible, and not depend on mechanical means altogether.

There is, perhaps, nothing more important in the equipment of a hospital than the plumbing, for through the plumbing pipes go all of the filth and product of disease, and it is most important that this work be done well, and and that all pipes and fixtures on the room side of the trap, at least, be get-at-able for cleaning, not only the outside, but the inside, that enough space around the fixtures should be allowed for cleaning and the simplest form of brackets and supports be used.



The bath tub for the patient should, I think, be so constructed as to allow the possibility of filling in the shortest possible time, the large inlet like the ocean steamship tubs



appears to be, then the over-flow (if there must be one) should be easily cleaned, if the trap is set above the floor as shown here, the water line is within easy reach of the hand and the pipes can all be cleaned inside. This tub is set high—making it easy for the nurse to assist, if necessary, in the bath.

With the bug-a-boo of sewer gas exploded, there is no reason why the private room, at least, should not have a wash basin.

The simpler form of surgeon's scrub-up sinks appeal to me, doing away with the complicated foot and knee valve which has come in to popularity within the last ten years, and having the simpler elbow valves for the non-hand touching-valve, is only wanted after the surgeon has done his scrubbing-up.

I have referred many times to the St. Georg Hospital at Hamburg. I have done this for two reasons, first, that the available material for slides were better, and, second, that the St. Georg embodies the greatest number of new up-to-date ideas that I found in my visits to over thirty-five hospitals in Europe, and I want to introduce you to the architect, the man whose study and knowledge of the hospital problems has developed some of the finest things in this line in Germany, and, I believe, in the world, Baurat Dr. F. Ruppel, and I would not forget the name of Hoffman, whose work at the Virchow, at Buch and the newer hospitals about Berlin, or, Schachner, who designed the splendid hospital at Munich, and the many others who have specialized along this line to produce the best results for the care of stricken humanity.

I want to acknowledge the courtesy of those hospital superintendents and others who have loaned me photographs and slides for this paper, to the material men for the good examples of hospital fixtures, and to you all for listening to this long harangue.

PRESIDENT: These two papers are now for discussion, or if any members desires to ask any questions of Mr. Stevens or Dr. Brown, we will be glad to have them do so. We have but one more paper this evening. I received a telegram from Mr. Parke, saying that he was unable to be present, and as he did not send his paper, we, of course, cannot have it. If there is no discussion on these two papers that have just been presented, I will call for the next paper by Dr. Kellogg. Dr. R. H. Harris, his associate, is here to read his paper.

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## THE SANITARIUM HOSPITAL.

DR. J. H. KELLOGG, BATTLE CREEK SANITARIUM, MICH.

The hospital originated in the exigencies of warfare. The wounded soldiers in the besieged city were gathered into the churches as the most available and commodious places in which to care for them. In some of the older European cities one may find hospitals which were originally churches and still wear the general aspects of a church,—windows far above the floor, and big stained glass reredos, even pulpit and crucifix. Every hospital still preserves the evidence of this emergency beginning, in the great ward rooms and the long rows of beds, uniformed attendants, and general military appearance.

Of the three great professions, medicine seems to be by far the most conservative; and it has only been in comparatively recent times that the fetters of precedent and ancient sanction have been loosened sufficiently, to permit any material departure in hospital construction and management, from the methods which originated in the emergencies of warfare a thousand years ago.

That this was necessary has long been recognized in the provision by all modern hospitals for private patients in separate rooms and special rooms for critical cases. But even this modification of the cathedral-like ward system is very modern, and there are to-day but few great hospitals which furnish more than a very limited number of rooms, in which the privacy, quiet and special attention now recognized as being desirable and even essential for the highest welfare of the patient, may be secured.

The marvelous development in physical or physiological therapeutics within the last century has so enriched our therapeutic armamentarium that the facilities and methods of the old-time hospital have proven altogether inadequate. The result was at first the development of a variety of institutions, each representing some single new therapeutic agent,



the votaries of which in their enthusiasm regarded as a panacea for human ills and so exploited it to the neglect of other measures perhaps equally valuable. This is the origin of water cures, which were so numerous both in this country and Europe about the middle of the last century, and the numerous electrical institutes, movement cures, diet cures and light establishments. The inadequacy of the hospital to meet the demands of scientific progress, may, perhaps, be to no small degree responsible for the empirical exploitation of so-called natural or physiscal remedies in the early history of these therapeutic measures; and, perhaps, also, for such pseudo-medical practices as osteopathy and chirporactic, and even Christian Science and magnetic healing.

As a student of the late Dr. Austin Flint, one of the most progressive medical men of his time, the writer became deeply interested in physiologic methods, and thirty-five years ago embraced an opportunity which offered, to make an attempt to bring together under one roof in an organized form all the resources of modern scientific medicine. The beginning was very small—two or three two-storey wooden cottages and a dozen patients. I was encouraged in the attempt by a paper by Dr. S. Weir Mitchell, read about that time before the American Medical Association, in which he emphasized the need of institutions where patients could have the advantages of rest, scientific feeding, massage, applications of electricity, baths, and other like measures. These therapeutic means were at that time not available in any hospital in the United States, nor in any institution under scientific management. The idea was to add to the advantages of the ordinary hospital all the recently developed resources of physiological medicine, and to make provision for the practical application of the discoveries of Voit, Pettenkofer and others in metabolism and scientific nutrition.

One of the early problems was the selection of a suitable name. The word "sanitarium" was coined to meet the case, by modifying the word "sanatorium," which was then de-

finer by Webster's dictionary as "in England a health resort for invalid soldiers." So far as the writer knows, this was the first use of the word "sanitarium." The present usage of the word applies it to any establishment which affords hotel or boardinghouse accommodations in connection with baths or any other curative means. Hence the title of this paper, "The Sanitarium Hospital," a term which indicates more clearly than does the word Sanitarium as now used, the writer's conception of what an up-to-date institution for the treatment of the sick ought to comprise.

Although the ultra-conservatism of the medical profession has greatly delayed the recognition of the newest therapeutic measures of a physical sort by the great mass of medical men, the time has certainly come when no great medical institution can fill the prescriptions of scientific medical men without an equipment which includes all the great healing agencies embraced under the general term "physiotherapy."

Nearly every insane asylum in the United States has within the last ten years installed a hydriatic department, and is making more use of water as a means of relieving insomnia, improving metabolism and combating the physical causes of mental disease than of all drugs put together. A few years ago I heard Dr. Edwards, then superintendent of the State Hospital for the Insane at Kalamazoo, Michigan, in a discussion of a paper on hydrotherapy read before the Kalamazoo Academy of Medicine, make, in substance, the following statement: "Although we have twice as many patients at the present time as we had twenty years ago, a recent examination of our books shows that we use less sleep-producing drugs in a whole year than we formerly used in a single week. When our patients do not sleep or are disturbed, a bath of some kind or a wet cloth applied somewhere, quiets them and sends them off to sleep." The medical treatment of the insane has been completely revolution-

ized in this country, as previously in France and other European countries, by the introduction of hydrotherapy and other physical measures.

But what hydrotherapy is doing for the insane, for neurasthenics, dyspeptics and valetudinarians, physiotherapy is capable of doing for all curable human maladies. No intelligent therapist now regards the outdoor treatment as a remedy specifically restricted to use in pulmonary tuberculosis, in the same sense in which quinine is related to malarial infection. A New York hospital that has an open-air ward on the roof, has not only saved the lives of scores of patients sick unto death, but has demonstrated to the whole country and to the whole world the value of the open-air method in pneumonia. The Johns Hopkins Hospital has furnished an equally striking demonstration of the value of outdoor exposure in surgical cases. It is safe to say that all great hospitals erected in the future will make ample provision for the exposure of patients to the sun and fresh air, and will provide an adequate equipment for the efficient application of scientific hydrotherapeutics.

When it is known that the first shower bath ever used was made and employed in an Edinburgh hospital, it is surprising, indeed, that the shower and the douche in its various forms, with other hydriatic measures, should have been so long left to be the monopoly of empirics and enthusiasts, and should only now, after more than a century of neglect, be just beginning to find the recognition which rightfully belongs to them.

The resources of physiotherapy are numerous and varied. The marvelous vitalizing powers of light, so well known to the ancients and recalled to the attention of the medical profession in recent times by the classical experiments of Finsen, are needed in every hospital. The hospital equipment should include cabinets, both fixed and portable, photophores, arc light, and other facilities for the application of

radiant energy in the form of actinic and luminous heat waves. By these means, the sunlight stored up in coal fields may, through the agency of the electric dynamo, be resuscitated and brought to do service in sick rooms from which sunshine is excluded by clouds or opaque walls.

Electricity, though far more limited in its application, is capable of rendering inestimable service, and must be represented by an efficient equipment in the sanitarium hospital of to-day. The galvanic and sinusoidal currents render especial service by stimulating metabolism and administering passive exercises to bedridden patients, and otherwise.

It is needless to mention the value of the X-ray, a development from electricity, both in diagnosis and therapeutics, for this is universally recognized.

Medical gymnastics, especially the Swedish system, massage and mechanotherapy, are powerful therapeutic means which are capable of contributing greatly to the advancement toward recovery of the convalescent surgical or fever case, as well as the victim of chronic disease. I fear we do not always appreciate the injury which the average hospital patient suffers from confinement in bed. Massage, medical gymnastics and mechanotherapy, especially in connection with the sinusoidal electrical current, afford a perfect means of counteracting this deteriorating influence, which often defeats the efforts of the most expert surgeon.

But, perhaps, the most important feature of the sanitarium hospital is the dietetic department. There is no way in which a hospital patient can receive greater help toward recovery than by right feeding. A special study of the Sanitarium hospital must be, to give to its patrons the benefit of the very latest discoveries in metabolism as related to nutrition and the very highest expression of the culinary art directed and applied with scientific acumen and trained experience. The diet kitchen already has a recognized place in

every hospital. But why should a hospital have any other sort of a kitchen than one which is scientifically administered? No patient ever enters a hospital who may not be benefited by scientific regulation of his diet.

Is there not great room for progress in matters dietetic in the average hospital? Certainly the Sanitarium hospital, which should represent the modern medical institution in its highest expression, must give paramount attention to dietetics. This requires a large corps of trained people—trained dietitians, trained cooks, nurses and doctors trained in the physiology of digestion as revealed in the most recent researches and acquainted with the results of the latest studies in metabolism. The preparation of foods must be conducted with the same intelligent and scrupulous care as the compounding of drugs. Foods may be served with such accuracy that the calorific value of every serving may be known. A physician knowing thus the actual worth of each article served to his patient, in proteins, fats and carbohydrates measured in calories, may make his prescriptions of diet with the same precision with which he prescribes a laxative or a heart stimulant.

One by one, the great resources of physiotherapy have been rescued from empiricism and charlatanism and placed under scientific control, and the time has certainly come when the feeding of the sick should be taken wholly out of the hands of the ignorant and untrained, delivered from the rule of thumb and fancy, and elevated to its proper place among the agencies for the promotion of recovery.

The Sanitarium hospital must of necessity maintain a thoroughly equipped clinical laboratory. The therapeutic instruments of such an institution cannot be intelligently applied without the aid of such accurate knowledge as only a modern clinical laboratory can give. Every prescription must be made with a view to the removal of the causes of the pathological condition present or the regulation of some



physiologic process by which the remedial forces of the body are seeking to effect a cure.

But the Sanitarium hospital, no matter how perfectly constructed, ventilated, heated, lighted and equipped, needs, most of all, one thing—intelligent direction, guided by a broad knowledge of the resources of modern scientific medicine and a versatility and aptitude in the application of these resources. It is very easy to fall into ruts and to continually play upon one therapeutic string. The Sanitarium hospital should be a place where properly trained physicians will undertake to give their patients the benefit of all the curative resources known to man which can be made available in one place. Organized team work is necessary, so that the patient may have the benefit of what might be termed a full orchestra of therapeutic agents. In too many hospitals there are hydriatic, electrical and other equipments for physiotherapy which are rusting in disuse. The profession are, however, beginning to recognize that the physiological era in medicine has arrived, and there can be no question that in hospital and private practice, but especially in hospital practice, physiological and so-called sanitarium methods will in the future play a far greater part than in the past.

Not the least important function of the Sanitarium hospital is the education of its patrons in correct habits of life. Most chronic diseases are the result of errors in personal habits in relation to diet and other matters of individual conduct. The mortality from chronic diseases is rapidly increasing; has doubled, in fact, within the last thirty years, a fact which affords indisputable evidence of the necessity for a campaign in behalf of right living. If out-of-door air is valuable as a therapeutic measure, it is equally valuable as a means of prophylaxis. If baths and other means re-enforce vital resistance and so aid the sick man in his battle for recovery, these measures are capable of rendering even greater service in fortifying the body against disease. The



people are dying for lack of knowledge, and the unusually favorable opportunity afforded by a few weeks' sojourn under daily medical supervision ought not to be allowed to pass unimproved. A stay in a hospital ought, in fact, to be a period of health training of both mind and body, so that when the patient has reached recovery and the time for his departure, he will be fortified with knowledge of ways and means by which he may avoid sickness in future and so make his life better worth living through increased health, happiness and efficiency.

This paper has not undertaken to make a complete description of what the Sanitarium hospital ought to be, but only to present a general outline of the writer's concept of what a complete and highly organized medical establishment should include.

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A full expression of the Sanitarium hospital idea will be found in various blank reports, diet lists, etc., and especially in the booklet, *The Battle Creek Sanitarium System*, which may be had on application.

PRESIDENT: This paper is now open for discussion. You know we have been accused of building our hospitals for the surgeons for a good many years. The Sanitarium Hospital offers an opportunity for the physician. Dr. Hurd, will you open the discussion on this paper?

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#### DISCUSSION.

DR. HURD: The Sanitarium Hospital thus far has been a sort of omnium gatherum. It has usually started out as one thing and developed into something else. Almost all our present sanitariums started out as a fashionable health cure, or something of that sort, and gradually developed into more important things.

The Sanitarium of Dr. Kellogg was started as the result of a vision, and when I first knew about it, it depended wholly and entirely upon water; it was simply a water cure, and from that has grown a very excellent institution where good work is being done, not only in the treatment of disease, but in teaching patients the laws of health.

The Sanitarium at Clifton Springs was originally started as a religious institution for the care of dyspeptic ministers and feeble missionaries, people who had come back from living in the tropical countries, who wanted rest, needed exercise and all those soothing, elevating influences which come with that sort of work, and out of that has grown a very interesting department of the sanitarium, where very careful diagnosis is given of disease, where the patients' cases are carefully and intelligently studied, where medicine is prescribed in an intelligent way, where dietaries are carefully arranged, and the result has been a most useful institution.

I am very glad, indeed, that we have had this paper to-night, because it seems to me that the progress of events in this country is toward a greater use of the sanitarium hospital. I believe that Dr. Kellogg has been a very important agent in this direction. He started an institution which had no past, and at the time—I lived in the neighborhood then—I was afraid it would have no future. But his genius, his industry,—his indefatigable industry, have brought it to a very great state of perfection, and he is to be congratulated on what has been done.

I had no intention of discussing this question, I know very little about it; all I can say is that I believe the sanitarium has come to stay, and will continue to do good work.

THE PRESIDENT: Dr. E. B. Smith, you are connected with a sanitarium, what have you to say?

DR. E. B. SMITH: I did not have the pleasure of hearing everything that Dr. Harris read, but it must have been a very good paper. I do not like to hear it said that we are building hospitals for surgeons. I thought we were doing it for patients generally. Do not forget this. It is quite true that you have built hospitals for surgeons. We are now coming to an era where we see before us the white plague. The surgeons started way back long ago to build hospitals and build then for tubercular patients, and you have not finished building hospitals for tubercular patients, but we forget that in building these hospitals that we are trying to be too civilized, may be.

We appreciate what Dr. Kellogg has done in our good state, we are all proud of him, it is just such institutions as this that come out of just such beginnings as Dr. Kellogg's that have been a success. There seems to be a need of something to stimulate men and women, and that stimulus must come from not only the dollars and cents, not only pride of themselves, to build themselves up, elevate themselves, but 'here seems to be something else desired, and that something else is just what has made Dr. Kellogg's institutions the success that they are, the building up of something that will help men and women to live longer and live better.

In all abdominal cases we seem to think that sunlight is the very thing that we need to cure our cases, so we are beginning now to build hospitals along that line. I am sorry to say that on the screen I did not see the new hospital built in Dublin; I think it is just about completed; it may be in a year and a half. That hospital is built in pavillion style, not only is the patient looked out for, but the officers of the instiution, commencing with what they call the manager there, and not stopping till it gets down to the nurses. The nurses have their own quarters, they have their own directors' room. If there is anything in this country that we ought to be proud of, it is the nurses that we have. We have the best class of nurses in the world, not excepting any. We have the best trained nurses, we have nurses brought from the best walks of life in our nurses' association, and that is helping us; that has helped Dr. Kellogg. Take away his nurses' organization at Battle Creek and you cripple him. It is too bad that more of us cannot see the good in doing righteous things and may be we would build more hospitals and build them better, along the lines that Dr. Kellogg has originated.

PRESIDENT: Is there any further discussion?

Dr. Harris, do you wish to say anything in closing?

DR. HARRIS: No, thank you.

Adjourned to meet at 10 a.m. next day.

WEDNESDAY, SEPTEMBER 20—MORNING  
SESSION.

PRESIDENT: I wish to announce that I will appoint as the Committee on Time and Place of Meeting Dr. R. R. Ross of Buffalo, Miss Mary L. Keith of Rochester, and Dr. J. L. Freeland of Indianapolis. This Committee is to bring in a report Friday afternoon.

The Chairman of the Committee on Constitution and By-laws is not present at this session, and I will appoint Dr. P. E. Truesdale, of Fall River, on that Committee in his stead. I will ask Rev. W. S. Steen to act as a member of the Auditing Committee, with Mr. Cosgrave, in the absence of the other members.

SECRETARY BROWN: I should like to remind the members of the Question Box. If they will kindly forward any questions they wish to have answered, to this desk sometime during the day, they will be ready for reply to-morrow and Captain Townley will be glad to select the various members who will respond to those questions. I am also asked to say by the Treasurer that he is waiting with outstretched hands for any fees that are not yet paid.

PRESIDENT: If there is no new business to come before the Convention, we will proceed with the papers.

## HOSPITAL TREATMENT OF COMMUNICABLE DISEASES.

DR. D. L. RICHARDSON, SUPERINTENDENT CITY HOSPITAL,  
PROVIDENCE, R.I.

Members and Friends of the American Hospital Association.

When your Committee asked me to write a paper upon "The Hospital Treatment of Communicable Diseases," it was with some hesitation that I accepted for the reason that our experience along the lines on which we have been working has not been sufficient to draw absolute conclusions. You will not readily agree with all I have to say, but I beg to call your attention to a matter of vital concern to all infectious disease hospitals and to the general hospital as well. It relates to the hospital management of contagious diseases and the diminution of cross infection.

As fast as research work gives to us the causative organisms in infectious diseases, their source, habits, and longevity, so fast are we able to adapt this knowledge to the control of the disease in question. Before Read and his associates learned the method of transmission in yellow fever, all efforts were directed against fomites infection without controlling the disease. Two objects are now aimed at, to keep the mosquito away from the sick and the well, and to the efficiency of this method the nearly completed Panama Canal attests. Before the discovery of the plasmodium and its life history, the cause of malaria was supposed to arise from swamps, and protection against the exact carrier was entirely missed. To these may be added the knowledge that tuberculosis is largely transmitted by sputum, cholera and typhoid by intestinal discharges, Rocky Mountain fever by the tick, Malta fever by the goat, and numerous other examples. In fact, all that has been learned to date has narrowed the number of air-borne diseases until there is very good reason to believe that air-borne infection plays a very small part in the dissemination of disease.

Of the so-called "contagious diseases," with which our hospitals usually deal, the etiology of only one, namely diphtheria, has been demonstrated, and with the possible exception of this, the same ideas of air-laden infection is entertained about them. I want to present to you evidence from English and French hospitals and eighteen months' experience with this group in the Providence City Hospital to show that if they are transmitted by air at all, it is to a very limited extent.

It was the French who were first to doubt the air borne theory of disease and the importance of controlling contact infection. To Grancher of Paris belongs the credit of being one of the first to put these ideas into practice. He isolated contagious diseases in the wards of a general hospital. Wire screens were placed about the beds to indicate that certain precautions were to be taken in handling these patients. These precautions were based on the method of strict asepsis. From 1890 to 1900, among the 6,451 patients admitted to Grancher's wards, diphtheria was introduced 43 times and only once did the disease develop in the ward; scarlet fever was introduced 19 times and seven cases developed. Less success was obtained with measles, although infections were reduced two-thirds. But the evidence was conclusive enough to convince Dr. Grancher that even measles was not spread by air.

The numerous infectious hospitals in England and France which have taken up the work have developed different methods of separating patients. Out of Grancher's method grew the "barrier" system. This is the method of isolating patients in a common ward. In the beginning the beds were surrounded by sheets kept wet with bi-chlorid of mercury. Within this enclosure the patient's nursing articles were kept and asepsis was strictly observed when he was touched. At present the wet sheets have been dispensed with and a piece of tape is stretched about the bed. In one hospital, two uprights are set on the floor on each side of



the foot of the bed, and a cord colored to indicate the disease is stretched between. These signs are merely to indicate to the nurse that precautions must be taken.

Another method is the so-called cubicle system. The cubicles are small rooms with partitions more or less complete. In many instances the partitions are about seven feet high. They are of silicon-plaster, glass, or a combination of both. The rooms are arranged on either side of a common corridor.

Still another method is the box or room system in which separate rooms with complete partitions are used. These rooms may lead off on both sides of a common corridor or be arranged on one side of it.

The cellular block system developed at the Plaistow Hospital, London, consists of two rows back to back; the partitions are complete and of glass. The doors from each row of rooms lead to an open air corridor on each side of the building. The nurse must go out of doors to go from room to room, but can have her patients all in view from any one of them.

In the Plaistow Hospital, Dr. Biernacki has been using the barrier system extensively, as well as the cellular block system. In the barrier system, the beds are placed a considerable distance apart. Two upright standards are placed on either side of the foot of the bed and between them is stretched a cord to denote that precautions are taken. Each patient has his own nursing articles within the barrier and the nurse dips her hands in disinfecting solution after handling the patient. In a recent letter he states that it would be a great advantage to have a wash-basin, supplied with hot and cold water, between each two beds for washing the hands.

Dr. Biernacki writes that he would isolate the following diseases with the barrier system:

1. Diphtheria.

2. Whooping Cough.
3. Mumps.
4. Rubella.
5. Typhoid.
6. Septic Infections.
7. Ring Worm, except when not additional to Scarlet Fever.

They do not attempt to isolate measles or chicken-pox, and hesitate to do so with scarlet fever. In their cellular block system, they treat all the above diseases and typhus also. The nurses pass from one room to another, observing aseptic precautions. In the block there has been no cross infection in three years.

He quotes no statistics relative to his barrier work, as they have not reached a final decision as yet. A series of articles on the nursing of infectious diseases by Dr. Bier-nacki will be found in the *British Nursing Times*, May 16th to December 12th, 1908.

Dr. F. Foord Caiger, Medical Superintendent of the South-Western Hospital, London, reports on eighteen months from January 1st, 1907, to June 30th, 1908, upon the cubicle system. The partitions are seven feet high, the lower half being granite silicon plaster and the upper half glass in a metal frame. Seven hundred and four patients were placed in these cubicles, of whom 289 were scarlet fever convalescents who were placed in them two days and nights before their discharge. The remaining 415 were isolated in them for the following reasons:

- (a) The original diagnosis was uncertain;
- (b) The disease, though recognized, was one that called for separate isolation;
- (c) The patient had been exposed to another disease prior to admission and therefore, was possibly incubating a second disease;

- (d) The patient was suffering from more than one infectious disease.
- (e) The disease was obviously of a non-infectious nature.

In addition to the 289 convalescent scarlet fever cases referred to above, the following diseases were placed in the cubicles:

163 cases of Scarlet Fever in the eruptive stage of the disease.

82 cases of Rubella.

22 cases of Measles.

31 cases of Diphtheria.

17 cases of Whooping Cough.

Of these 704 patients, 20 contracted a second disease in the cubicles. Three of this number, however, were incubating the disease on admission, and a fourth was infected by a ward maid who was suffering from diphtheria. Of the sixteen diseases arising in the cubicles, six were scarlet fever, six were chicken-pox, two were rubella, and two were measles. In two instances (one chicken-pox and one measles) there had been no recognized case of the same disease previously in the ward for a period of six weeks and two months respectively. Thus only fourteen persons apparently contracted another disease from patients in the cubicles. It will be seen that no case of whooping cough or diphtheria developed. Dr. Caiger concludes that of all the diseases mentioned above, chicken-pox is the only one which he has ceased putting into cubicles because of the six cases arising in the first six months of the period reported on.

Dr. Thompson, of the North-Eastern Hospital, London, reports on an experience of two years with the cubicle and separate room systems. To the cubicles, 1,200 patients were admitted. The following cross infections have developed:

Scarlet Fever, 5 times.

Rubella, 3 times.

Measles, twice.

Whooping Cough, once.

Chicken-pox, 3 times.

Diphtheria, twice.

His conclusions are rather conservative. During the last twelve months he placed in the cubicles doubtful cases of scarlet fever and diphtheria and is adverse to placing other infectious diseases in them.

To the box rooms 660 patients were admitted suffering from the various infectious diseases, save chicken-pox. The following cross infections developed:

6 cases of scarlet fever.

3 cases of rubella.

2 cases of measles.

1 case of whooping cough.

3 cases of chicken-pox.

Other hospitals which are doing aseptic nursing are the Pasteur Hospital, Herold Hospital, and Hospital des Enfants Malades, of Paris; the Monsall Hospital, in Manchester, England; I understand that the work is just beginning in Germany.

The Pasteur Hospital has, I believe, a very excellent equipment and is doing very efficient work with the cubicle system with aseptic nursing.

I will now offer for your consideration an experience of eighteen months, March 1st, 1910, to September 1st, 1911, at the Providence City Hospital, with aseptic nursing of infectious diseases. Both the separate room and barrier systems have been employed.

Patients are accommodated in three parallelly situated, two-storey buildings, one each for diphtheria and scarlet fever, and one an isolation building, so called for all other infections and mixed cases. Each floor of the diphtheria and scarlet fever buildings is divided into a ward of twelve

beds and seven or eight rooms arranged on either side of a central corridor. These latter vary in size, containing from one to five beds. The ground floor has also an admitting room, connecting with a doctors' gown and wash room, and a patients' bath. The large number of small rooms furnishes the opportunity for isolating mixed or doubtful cases, and for detaining new cases a certain period of time before they are allowed with convalescents.

On the first floor of the isolation building are twelve single rooms arranged on either side of a central corridor. Ten of them are arranged directly opposite so that the doors open opposite to each other. Beside each door and opening into the same room is a full-sized window which permits of better observation of patients by the nurses and keeps the patients better contented by permitting them to see their neighbors across the hall. The partitions rise to the ceiling and are of studding, lathing and plaster. Each room is provided with a wash basin without any plug in it, and levers to be operated by the forearm to turn on hot and cold water, which escapes through a single spout, mixed to the desired temperature by operating the levers. There are two hooks on the wall, one for the doctor's gown and one for the nurse's gown. Over the wash basin is a horizontal, nickel-plated rod for hanging the towels. There is also a small, high shelf for thermometers, etc., which must be kept out of the child's reach. The walls of all the ward buildings are painted with an enamel finish so that soap and water can be freely used without damage. This floor also has its serving kitchen, toilet and bath rooms. In the serving room is a large utensil sterilizer for sterilizing dishes, medicine glasses, etc., which come from the patients.

The construction of the second floor is the same except that the rooms contain from one to five beds, making it possible to accommodate in the same room several patients isolated for the same purpose.

The doors to all the room in the isolation building are always left open unless there is some unusual reason for closing them.

The dormitory for nurses is in the administration building; that for female help in the service building and for male help over the power house and laundry.

The administration of the hospital has been worked out along the lines of avoiding contact infection. It has been our aim to avoid cross infection and infection of employees, by strict asepsis. Every new nurse and employee who has to go into the wards is thoroughly impressed with the idea that if he gets sick it is most likely his own fault and probably due to putting his fingers or something else contaminated in the ward into his mouth; they understand that if any cross infection develops, they are liable to investigation as to the care they exercise in their work. The following set of rules is posted in all nurses' and employees' rooms:

TO AVOID TAKING AND CARRYING INFECTION.

Keep fingers, pencils, pins, labels and everything out of your mouth.

Keep and use your own drinking glass.

Do not kiss a patient.

Wash hands often, and always before eating.

Keep out of doors as much as possible and always sleep with window open.

Do not touch face or head after handling a patient until hands are washed.

Do not allow patient to cough or sneeze in your face.

Do not allow patient to touch your face.

Do not eat anything that patient may wish to give you.

If taking a drink or lunch be sure and use the nurse's dishes.

Put on gown or change uniform when going into the ward.



On leaving ward always wash hands.

Always remember that infectious diseases are taken and carried by contact and *not* by air infection.

Every employee has a culture taken on beginning work and before going into the wards. Everyone must be vaccinated before or soon after entering on their work.

I will not attempt to present to you all the details of our technique, but will outline the more important, first those relating to the general administration, and, secondly, the more direct care of the patient.

The resident physicians have their quarters in the administration building and all eat in the same dining room. While working in the wards, white duck suits are worn, and in each ward a gown is put on if it is necessary to examine patients, thus coming in direct contact with the bedding and patient. On leaving the ward, the gown is removed in the gown and wash room, and the hands are carefully washed with soap and water in the special basin to which I have already referred. Great care is exercised when not having a gown on to avoid allowing any part of his clothing to touch the bed, bedding, or anything else.

The nurses all sleep in the same home and eat in the same dining room. When off duty they are allowed to leave the hospital as freely as from any general hospital. When the nurse goes on duty, she goes to the dressing room for that ward where she has two metal lockers, one for clean clothes and one for infected clothing. She puts on her ward clothes and goes to the ward. She changes her dress, cap, apron, and bib only. When going off duty, she removes her infected clothing first, washes hands and face, and then puts on her uninfected uniform.

The maids and other help put on gowns when entering the wards. These gowns have short sleeves so that the sleeves will not be contaminated. Otherwise they observe the same care as do the nurses. The ward help eat in the

same dining room and sleep in the same home as do all the other help, and they, too, are free to come and go when off duty. It is insisted that every case of illness among nurses and help be reported at once that no mild infection may be overlooked.

The same kitchen furnishes food to patients and employees. Food supplies are sent to ward kitchens in paper bags and paper trays and these are destroyed. Such dishes as must pass between kitchens are boiled before leaving the ward and are washed again in the main kitchen.

All the hospital linen is done in the same laundry. The washers are used indiscriminately, although clean and infected clothing are not washed at the same time. One man, the washer, handles all the infected clothes. The laundry is collected in large canvas bags in the basement into which the ward clothes fall through a chute. These bags are put on a truck and taken to the laundry where they are put directly into the washer. If sorting is necessary, it is done on the cement floor in front of the washers, after which the floor is washed down with a hose with hot water. The washing is continued for forty to sixty minutes in ordinary washers on which there is no steam pressure. When removed, the clothing is considered to be sterilized and treated as clean laundry. The clean clothes are returned to the wards tied up in square pieces of cotton cloth, and this goes to the wash before being used again.

The greatest source of infection is certainly the patient himself, and if we are to minimize diseases arising in the hospital, we must have very careful regulations and insist on their obedience. Our method of procedure has been based on the contact infection idea and we have disregarded air transmission unless one chooses to insist that the coughing of a patient directly into one's face is air-borne infection. I will not weary you with too many details, but will trace briefly the method of care from the time the ambulance goes to the house until the patient is ready to walk out of the hospital.

The various infectious diseases, including tuberculosis, are brought to the hospital in the same ambulance and in a coupe. There is nothing peculiar about their construction except the interior which permits of the free use of soap and water without damage. For every disease there are two lockers in the stable, one of which contains a long washable coat for the attendant, and the other a similar coat for the driver. Careful inquiry is made as to the presence of other recent previous infection of the patient or of any one in the house. The patient is wrapped in blankets and brought to the hospital, where he is placed in the appropriate admitting room. The driver and attendant return to the stable, remove their coats, and wash their hands. The infected blankets are put in a hamper and later sent to the laundry. The interior of the coupe or ambulance which has come in contact with the patient, is washed with soap and water. I have not been able to trace any infection to the ambulance.

The patient stays in the admitting room until the admitting officer has examined and recorded his history and physical examination. A culture of nose and throat and vaginal smear is taken before entering the ward. Even though it may be an uncomplicated case belonging in that ward, every such patient is held in detention from five to seven days, and often longer. Detention means placing in rooms off the ward used for the purpose where aseptic precautions are observed. Should there be any doubt at all about the diagnosis, or exposure to or suffering from mixed infections, the patient goes to the isolation ward, which I shall soon describe, or else is barriered by placing a red card on the bed.

Briefly our technique in the care of barriered or, as we call them, red card cases, is as follows: The patient may occupy a single room off the ward or there may be several red cards in the same room. The children are kept in bed

and not allowed toys or anything which can be thrown from bed to bed. The hands of doctors and nurses are washed before and after handling a patient. Each patient is supplied with a thermometer, basin, pus basin, bed pan, and so forth, which stay on a stand by the bed. There is a gown to be used when coming in intimate contact with the patient. All dishes are boiled after using.

The construction of the isolation wards has been referred to. The furniture is small in amount and so constructed that it can be easily cleaned. It has proved to be the most valuable section of the hospital. In it we have not hesitated to treat any of the so-called contagious diseases except smallpox, in any stage, as well as cases for observation only. We are obliged to treat a few cases of measles, chicken-pox, whooping cough, and rubella, and it has been very convenient and we believe safe to use these single rooms, equipped as they are. It saves opening a large ward and furnishing a separate supply of nurses and maids for each.

We confine the infection to the rooms immediately occupied by patients. We expect that the corridors, serving kitchen, linen room, bath and toilet rooms are as safe and free from contagion as those of any general hospital. The same nurses care for the patients on a single floor. The nurse washes her hands with bar soap in the running water and dries them on an individual towel every time she touches the patient or anything in the room. If she comes in close contact with the patient she puts on a gown. Each patient is supplied with thermometer, urinal, basins, ice bag, heater, and so forth, everything necessary for constant use on the patient. All dishes and nursing apparatus coming from these patients are put directly into a sterilizer if steam can be used, or 1-20 carbolic for rubber and glass goods. Bed pans and urinals are emptied into the hopper and are put into a tub of 1-20 carbolic, where they are kept for an hour before removal to the warming rack.

Small children who would play on the floor are kept in bed throughout their hospital residence. Larger children or adults are allowed up, but confined to their rooms, except being allowed out of doors, where they are also kept apart. The doors of the rooms stand open all the time, and this practice, together with the extra corridor window, allows patients to see each other and to talk back and forth, and they seem to be very contented.

When a patient is discharged, the linen in his room is sent to the laundry, the mattress and pillows to the steam sterilizer, and nursing articles are sterilized. The bed, wash-basin, table, chair, floor and walls within easy reach are simply washed with soap and water. Preferably the room is aired for twenty-four hours, but if we need it we have not hesitated to put a new patient into it immediately. Fumigation is never done.

Every discharged patient receives a thorough soap and water bath, including a shampoo. The clothing has been sterilized by steam, ten pounds for thirty minutes, so far as possible. Those articles which steam would injure are treated with formaldehyde vapor in the same chamber, to which one to two pounds of steam has been added.

You will have noticed that we do not use any disinfectant solution for the hands. It has seemed to us that if we could make it convenient enough so that every time hands became infected they would be washed with soap and water, it would be sufficient. There is no antiseptic solution which is efficient under an immersion of less than one minute. It is impracticable and impossible to get so long an immersion after washing, done by busy nurses, what is more important all the solutions injure the hands, setting up a dermatitis which is a good soil for infection to linger upon. The results which I shall directly present, seem to substantiate this practice.

Except during the first few weeks after the hospital was opened no prophylactic antitoxin has been administered to nurses, help, or to patients. Among the 128 nurses, graduates and pupils, which have worked and are working in the wards, the following diseases have developed:

Diphtheria, 3 times.

Scarlet Fever, 3 times.

Rubella, twice.

Mumps, once.

One physician had diphtheria and a maid had scarlet fever, making a total of twelve among all attendants. One thousand and one hundred and seven patients have been admitted to the hospital up to September 1st.

The following diseases have developed among patients in all wards save the isolation wards:

1. One case of diphtheria in the scarlet fever ward.
2. Five cases of measles in the scarlet fever ward from some unknown sources.
3. One case of rubella.

Since June 4th, 1910, no further cross infections have developed among patients admitted and discharged from the diphtheria and scarlet fever wards.

I want to call your attention particularly to the results in the isolation wards where we have not hesitated to place any disease in any stage, or cases for observation only. Three hundred and forty-five have been admitted and discharged. Many of these patients were suffering from more than one disease, so that the number of sources of infection was as follows:

	1911.	1910.	Total.
1. Scarlet Fever .....	69	38	107
2. Diphtheria . . . . .	29	18	47
3 Measles . . . . .	18	38	56
4. Whooping Cough .....	25	29	54
5. Rubella . . . . .	14	2	16
6. Chicken Pox ....	8	6	14
7. Mumps . . . . .	4	5	9



8. Gonorrheal Vaginitis ..	7	7
9. Erysipelas ..	1	1
10. Variola ..	1	1
11. Acute Tuberculosis ..	1	1
12. Positive Cultures ..	31	52
<hr/>		
Sources of Infection ..	200	365
Non-contagious Cases ..	23	48
<hr/>		
Total ..	223	413

Of these 345 patients 296 were in the wards more than one week and 49 less than one week.

The following diseases have been transmitted: One case of measles and one case of chicken-pox. Following these for nine months, nothing developed. Within one week, in the latter part of January, 1911, four cases of scarlet fever developed, and a fifth about three weeks later. Of these five cases the diagnosis of only two was definite. They were mild cases. The other three showed very little or no constitutional disturbance; one did not desquamate at all, and the other two desquamated a very little. We have, however, classed them all as scarlet fever. There has been no cross infection since February 23rd, 1911.

I want to add that during the better part of the period reported on, much of the work has been done by pupil nurses who were sent to the isolation training for about two weeks only. We are planning, however, to have most of it done by a permanent staff.

It might be of interest to note that we have treated advanced cases of tuberculosis in the second storey of the diphtheria building for sixteen months, and there has never been a case of diphtheria among them.

This departure from the customary methods in vogue in this country is due to Dr. Chapin, Superintendent of Health of Providence. The special features of construction with aseptic nursing in view are his work entirely. To him belongs the credit of introducing these advanced sanitary ideas.

PRESIDENT: I will ask Dr. Hastings, Health Officer, Toronto, to open the discussion on Dr. Richardson's paper.

**DISCUSSION.**

DR. HASTINGS: It affords me more pleasure than I can properly express to have the privilege of opening the discussion on what I presume is the most important subject that we all have under consideration, and that is the control of communicable diseases. When the immortal Thomas Carlyle many years ago said that only one person out of five thousand thinks, he gave a wonderful shock to the intelligence of humanity, but those who have made observation in regard to the slowness with which antisepsis and asepsis have advanced can fully appreciate the truthfulness of the statement and come to the conclusion that he was probably a little conservative in his estimate of the real thinkers. It has taken over three-quarters of a century to educate the surgeons up to what wound infection really means. When we get back to the earlier histories, when Semelweiss, the young Hungarian in charge of the lying-in hospitals in Vienna, first drew attention to the fact that the enormous mortality in the lying-in hospitals was due to the infection carried to them by the house surgeons who were engaged in pathological work in the laboratories and in the dissecting rooms, this was particularly emphasized and impressed on his mind by the fact that one of these students died with symptoms corresponding very closely to those presented by the women in the wards who were dying of the so-called puerperal or childbed fever. Notwithstanding the indisputable evidence that he had to present to his colleagues at Vienna at that time, they practically ignored all that he had to say and thought that he was a crank and extremist. The result was that his opinions and his observations went for nothing and matters lay comparatively dormant along that line until some twenty to twenty-five years later, when Lord Lister brought forward the common principles of antiseptic surgery. When we consider the length of time since Lord Lister first introduced the principles of antiseptic surgery and you look back to the early recommendations at that time you will see how prominent in Lord Lister's mind was the fact of the possibility of aerial infection. There are few physicians and surgeons here that cannot recall the spray being required, to be played in the operating room before the operation was performed and one spray playing probably on each side of the patient during the process of the operation. It was not very long, however, until that was ignored and it was gradually dropped out, and in a comparatively short time it was discontinued. What did that discontinuance mean? It meant that the surgeons had convinced themselves that there was practically

nothing in aerial infection so far as wound infection was concerned. Now then, as the highest appreciation that I can possibly express of Dr. Richardson's paper, it would have been just as necessary for surgeons in past years to have required a separate operating room and separate attendants for a case of streptococcic infection and staphylococcic infection, as it is to require separate attendants and all the early precaution that has been taken for so many years in regard to the supposed aerial infection of communicable diseases. When we add to that the fact that we are familiar with, that germ diseases, like the germs of wound infection, have neither legs nor wings nor possess any vermicular action, we know positively they must be taken from one person to another, they cannot fly around through the air, and the possibility of being extended, as Dr. Richardson said, by dust or by coughing, we recognize that that truly is contact infection.

It is extremely important, in view of what Dr. Richardson has said, that we have a distinct understanding, and I hope Dr. Richardson in reply will explain later on his full understanding of what we mean by contact infection. If, when Lord Lister presented the principle of antiseptic surgery and the importance of antisepsis and asepsis in surgery, he had added that to medicine also and had emphasized the importance of antisepsis and asepsis in medicine, only the Recording Angel could tell how many lives that would have saved. I think the time has fully come for us to properly appreciate and to bend our energies along the lines of the sources and heads of infection. Certainly, the people of the United States are particularly indebted to Dr. Chapin, because it does seem to me for one to read Dr. Chapin's book, the very conservative method in which he lays down the principle of contact infection, it does seem to me that that ought to appeal to any intelligent mind, and when we apply the same thing, as I have already said, to contact in surgical operations, the same precautions that are necessary to prevent a spread of wound infection, the same precautions that are necessary to prevent the spread of the so-called puerperal fever (which we all know to be a matter of wound infection)—the same precaution that is necessary for the surgeon is necessary for the obstetrician and is necessary for the gynecologist is equally necessary for the physician.

There is one thing, Mr. Chairman, that Dr. Richardson did not quite emphasize as much as I should like to have it emphasized, and that is the fact that there is washing of hands and washing of

hands. Dr. Richardson said they do not require antiseptic solutions, that is very true, but it depends altogether on whether a man knows how to wash his hands or not. It is well for us to associate ourselves as much with the surgeon as possible and with the obstetrician until we learn how to wash our hands. We have to recognize the fact that it is not only washing the hands, but repeatedly washing the hands. The surgeon after he operates for a while knows, and it has been demonstrated by bacteriologists, that by pressing the fingers on the organs that are infected it becomes necessary to rewash the hands, if they are not wearing gloves. So it is in connection with all of us that are coming in contact with communicable diseases of any kind where there are germs, and when we recognize the ubiquitous character of these germs, all we can say is to emphasize to the fullest extent and as strongly as we can, "Wash your hands!" "Do not let anything come near the mouth except what you are going to eat, and see that it is sterilized before you eat or drink it."

PRESIDENT: This subject is open for further discussion.

DR. E. B. SMITH (Detroit): I do not think that this subject ought to go by without just a little bit more of a sidelight upon the subject. They tell us that cleanliness is next to godliness, and I think in this subject, above all subjects, does that apply. I remember visiting the American Hospital in the old City of Mexico. The operating room runs out to one side and just back of that, maybe twenty feet away, is the isolated smallpox hospital. I went into the subject with the attending physicians and also with a number of Americans in the City of Mexico, and they told me that they had never known a case of infection from that smallpox hospital, and yet they had a great deal of difficulty in training some of those semi-peons to understand that they must not go to the operating room after they had been near the smallpox pavilion. They would steer clear of the smallpox pavilion just as we have seen children when a house is placarded walk clear across the street to escape the sign, I suppose. I think we all have learned to poohpoo that idea at least, but have we got quite clear enough and definitely enough to ourselves to know what we are doing for the other people? A watchmaker will take hold of a watch and do many things with it that you and I could not do, because we would wreck the whole thing very quickly, but he does not, because he knows just how to do it, and thus you and I get careless sometimes in handling these diseases because we know how to handle them.

I think we all believe that contact does the business. We believe that a general hospital can be on one corner of the street or in the middle of a block and back of the lot we believe that we can have contagious diseases of every kind and take care of them. We believe that we can have them just a few feet from the main building. We believe they must come in immediate contact to carry infection, so that patients coming in with one disease ought to have all their wearing apparel taken care of in some definite place and be scrubbed. Sometimes when a surgical case comes in the patient will tell you, "Why, I had a bath a day or two ago." They do not want to take the second one, they are afraid the shock will be too great. That won't do. If we can get their garments away from them, if we can get whatever they use away from them and destroy it, there is no danger. Take the White Plague. We do not believe that one member of the family has to leave the house, and as some people have been teaching, but we do believe and we do insist, as scientific people, that the sputa should be taken care of and got rid of, that is all, and that you and I can breakfast and dine with them at will without being infected.

And so it is with diphtheria cases. I am glad this point was brought out where one infectious disease was on one floor, another on the floor above and yet no contagion. Does not that read the title clear? Because those nurses, those attendants, those physicians, those people taking care of those two different wards, knew what they were doing. But you cannot thrust that same condition into the family and among the laity, that is the trouble. You are beacon lights for these people, you have got to tell them what to do and how to do it, you have got to show them and show them, over and over again.

DR. H. M. HURD (Baltimore): I should like to ask Dr. Richardson whether, in his opinion, it would not be preferable to use rubber gloves instead of this everlasting and eternal handwashing with soap? We know, of course, that it is impossible to disinfect the human skin, that germs of disease remain in the skin no matter how carefully you wash it. With the use of the rubber gloves, is it not possible that it would be practicable to inculcate a better asepsis? If the nurse or attendant felt that it was his or her duty to put on a fresh pair of gloves, clean gloves, between two cases, would not there be less danger of cross infection?

PRESIDENT: Is there any further discussion before Dr. Richardson makes reply?

DR. SHARP: I think it would be a great mistake if we were to go away with the impression that all we had to do to prevent the spread of communicable diseases is to adopt the cubical system and a more rigid system of nursing. I believe that we cannot place as much reliance in statistics as would appear from the paper that Dr. Richardson has read. What assurance have we that the patient treated in the hospital, a scarlet fever patient, for example, had not had measles before diagnosis, and I think it would be a mistake if we did not continue to strengthen our lines rather than take down any. I think that the housing of nurses in one building, cutting off all the infectious wards, while there is a great deal to support it, in actual practice I believe that it would be better if we could keep our nurses, especially those going after a time from the training schools to take isolation work, by themselves, that is, those that were on scarlet fever, kept in a building by themselves. The same with the help. I think it is a very important matter with the help in our hospitals to isolate them as much as possible, especially while they are on duty. Another question that I would like to ask Dr. Richardson is this: in the matter of the handling of the clothing taken from infectious wards. I gather from the remarks that he made that there is no special system of handling this clothing, that it is not disinfected before being sorted; what evidence is there to show that those who are handling the infected clothing escaped? One would presume that certainly the infected clothing was a very easy way of distributing infection. As far as my experience goes, which is very limited, the number of cases of infection springing up from this handling of clothing is very limited.

DR. DREW: I should like to inquire of Dr. Richardson whether the dry sputa from a tuberculosis patient is not liable to be blown about, and, in regard to the mucus which is coughed from a diphtheric patient, is it not possible for the wind to blow this about so that other patients may contract it in that manner? I presume that that might be considered infection by contact, but what has been said in regard to bacteria flying about may possibly be misleading. We would not, of course, think of these bacteria flying about, but the idea which we have held for years is that the bacteria of tuberculosis may be blown about; is it or is it not true that the bacteria of diphtheria may be blown about?

DR. PETERS: I happen to be personally in touch with this work that has been done in Providence, because patients suffering from these contagious diseases were formerly treated at the Rhode Island



Hospital before being taken to the new City Hospital of Providence. I wish especially to emphasize the credit that ought to be given to Dr. Chapin about undertaking this work contrary to all our customs, practically, in this country, in caring for these very difficult patients to manage. There was a great question when this institution was started, and the plans were drawn, how the method of handling these patients different from the methods that they had been handled previously would be met with by the patients and by the laity in the community. The plans were drawn boldly by local architects under Dr. Chapin's supervision, the buildings were erected and the work was begun in treating and separating these patients on these lines, and so far as I know no criticism has been offered by the medical profession in Providence or the vicinity in the way of handling these patients. That was one of the delicate points that was under consideration when the plant was first started.

wish also to lay emphasis on the results as shown by Dr. Richardson's paper and give him credit for getting such results, which means that there has been everlasting vigilance, eternal drilling and instructing of pupil nurses and keeping everlastingly at this old hard job of repetition. We have a certain number of our nurses in training in this department constantly, and as I remember, only one or two nurses had developed these diseases in the hospital, and no nurse returning to our house from that hospital, so far as we know, has ever brought the contagion into our hospital.

MR. STEVENS: I would like to ask Dr. Richardson as to visitors. One point was brought to my mind very forcibly, in the Pasteur Hospital, in Paris, and that is the fact that friends of the patients who visit the patients from the balcony, on the outside of the building and through the windows are exposed to no danger.

DR. ROSS: Accepting all that has been said to be true, I yet fail to see the advantage of not separating diphtheria fever patients from scarlet fever patients. I do not believe it is possible to instruct every nurse so that she will carry out these rules implicitly, and I fail to see any economy in not separating the patients. Why not put the diphtheria patients in one division and scarlet fever in the other? It certainly would relieve a little of the tension.

DR. HOLMES: I want to bear a little testimony to Dr. Richardson's plan in Providence. They have a large plant and can keep them separate. I come from a small city and have handled scarlet fever and diphtheria for fifteen years. We keep diseases separate. I am always afraid of measles. We are not supposed to get any

measles. For a long time I was working on the contact theory, but did not know it was the contact theory. I have had very little trouble through cross infection. Dr. Chapin gave me courage on the measles question. I think every hospital is bound to get measles in, and we always should get measles in occasionally, and for the last two or three years, since I have been working on the contact theory and disregarding air, we have had absolutely no trouble whatever. I do not like to see hospitals built on the cubical plan, because the patients cannot be as happy. I think with supervision and proper watchfulness, the patients can be segregated, the diphtherias kept together, scarlet fever kept together, and the patients are much happier because they keep together; and they can have playthings. I know playthings are not considered good in hospitals on general principles, but I believe in them just the same. Of course there will be mixed infections, and all I do in mixed infections is to keep them in the buildings with the doors open, because we have no aseptic buildings. There is a great deal of need of education of the public in this matter, even of the general people who are supposed to take the lead in this matter in municipalities. Cities and smaller places have no hesitation whatever in segregating the contagious diseases of all kinds into one plant, but the same people will never think of any danger about any hospital building that had scarlet fever or diphtheria adjoining other buildings. All consider it terribly dangerous for people to live in the neighborhood of those buildings. There seems to be a very great inconsistency. It is a matter of education of the public in that way. The only disease that I have had any trouble with or have been unable to prevent the spread, has been chickenpox. There has been some weak link somewhere in chickenpox, because I have had trouble with that, but I have had no trouble with any other disease for years. It has been asepsis and good housekeeping. We have only three pavilions and sometimes there is more scarlet fever than diphtheria, sometimes the other way. If I need a building for another disease than is in there, I enter this building, put some woman to cleaning it with soap and water and put the other disease in, and I have no trouble.

DR. FREELAND: I wish to emphasize what I believe Dr. Ross intended. I believe in the contact theory, but it seems to me the best way to carry that out to-day, if you possibly could, would be to have a separate isolated hospital of contagious diseases. Three and a half years ago I was much interested in new plans that have

been supposed to be quite good, but they have been sleeping peacefully for three and a half years on account of lack of appropriation. We have been caring for contagious diseases in the building called the "Old Kindergarten," and we have attempted to isolate the different diseases in different rooms, and to our own way of thinking have successfully treated those cases without any cross infection. It is very nice of us to instruct our nurses and our help to wash and wash their hands; probably they will do that and they will centre their minds upon the washing of their hands, but frequently they forget some other very important precaution and violate the rule of contact, consequently, while we have had all contagious diseases in our hospital, it is my own way of thinking that if we could have that that is the best way of carrying out strictly the contact theory; in other words, isolate your contagious diseases and give strict enforcement to the law that all that come in contact with those diseases do not come in contact with others until they have been properly disinfected.

DR. HASTINGS: Might I ask Dr. Richardson if he will be good enough to emphasize the significance of chronic carriers as an explanation of these cases, which 's really a contact?

DR. RICHARDSON: I shall reply to some of the questions that I can remember. Dr. Hastings referred to thorough washing of hands. That is the most important thing, I think, in the control of diseases in a hospital, and it should not be attempted by placing a basin upon the table, because you cannot get that water changed every time somebody else wants to wash his hands. It must be done with running water, and the faucet so arranged that they can be used with the forearm or knee trip. We use the forearm trip, which turns on the hot and cold water, which escapes through a single spout, and you can regulate the temperature to suit your convenience. I would not attempt to continue this work without having these facilities. As a matter of fact, our red card cases are in the wards, scarlet fever and diphtheria wards where we have very few of these facilities that we are now having put in, and we have not isolated in these buildings some of the diseases that we would otherwise.

In reply to Dr. Hurd, relative to gloves, we have never tried this. I rather doubt whether it would be so convenient as hand-washing, and while, to be sure, the hands after being washed with soap and water are not perfectly sterile, does it matter so long as the results show that if there is any infection it is either attenuated, or at least does not give any trouble.

In reply to another question relative to the dependence on washing hand only for the control of diseases, it is certainly not the only method, and I think the most important thing, perhaps, is a correct diagnosis, and that is what we have aimed at in the City Hospital. If there is any doubt about the diagnosis whatever, we isolate that case for a certain period of time until we feel sure that the patient is not, for instance, in the incubation period of any of the infectious diseases. I think that if this is not done that the carriers, as Dr. Hastings has already spoken of, are liable to come into the ward. Of course, we can control diphtheria by cultures. Every child that shows positive or suspicious cultures is isolated. We have from 10 to 20 per cent. of our scarlet fever cases isolated for this purpose.

In reply to Dr. Drew, relative to the sputum, to be sure there is a popular opinion relative to the dry sputa flying about, and regulations relative to spitting and so on are quite common. There is laboratory evidence also to show that it may be carried in this way. But I do not believe even in tuberculosis the importance of contact infection has been emphasized enough, because in the same home several members of the same family are constantly exposed, and many times—one, two, three, up to seven members of the same family, may have the disease. In regard to the question of the contagion flying in the mucus, if it does, it is to a very limited extent, may be two, three or four feet, I cannot say just how far, depending upon the explosive violence of the cough, but I do not believe it will be carried across the hall, at least the work we have done already would seem to indicate that. Personally I do not fear infection from that source. If we get cross infections we believe that somebody has made a mistake, and in our epidemic of scarlet fever in January last year, while we cannot say absolutely that we know where that infection came from, we were satisfied of certain possibilities. As to the handling of clothing, I think that the danger of infected clothing is exaggerated. Most hospitals have an elaborate system in their laundry of sterilizing clothes, which I do not believe is necessary. I might say, in the eighteen months or more that we have been in operation, there has been no infection of any of the laundry help, but they, too, as well as every individual in the hospital, whether they go to the wards or not, are instructed as to how to avoid infection. I know that the help, while they may be a little tearful occasionally, when they first arrive, soon fall into line. Relative to Mr. Stevens asking about the visiting of patients, we have not allowed them to go into the wards. One reason is that to do so it would be necessary

to have somebody with every mother, because she will simply grab up the child and kiss it the first thing. If they could be controlled, it would be perfectly safe, but we have allowed them to see them through the windows, and, of course, our desperate<sup>y</sup> ill cases are permitted to have their parents present, but somebody is with them to see that they do not violate the rules. Perhaps there has been some misunderstanding of my statement relative to the attempt of treatment of scarlet fever and diphtheria. Understand that we have two separate wards, one for diphtheria and one for scarlet fever. Those are for uncomplicated cases. We believe in the spread of bacteria and we have a room where we isolate them until we are reasonably sure it is safe to put them in a ward. We have to take into the hospital measles and whooping cough, otherwise we would have to open a ward for them and furnish supplies and nurses and help. There are three things that I want to emphasize, first, the diagnosis; second, the training of help and nurses in the theory of contact infection, and, third, that I would not attempt to do this isolation work as we carry it out in the isolation ward without running water.

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## THE DEVELOPMENT OF TYPHOID FEVER AMONG HOSPITAL WORKERS.

BY MR. J. M. COSGRAVE, OF WINNIPEG, CANADA.

According to the records of the Health Department of the City of Winnipeg 6,781 cases of typhoid fever occurred there during ten years ending 1910.

During the first three years of this period the average was 398 per year. During the second three years something of an epidemic must have existed, as the average for that period was 1,351 cases.

The work of the Health Department is probably accountable for the very great reduction in the average for the last four years, this being 383, slightly lower than the average for the first period and a great improvement when the increased population is considered.

During the same period 3,858 cases were treated in the Winnipeg General Hospital, distributed as follows:—

1901 .....	264	1906 .....	599
1902 .....	268	1907 .....	245
1903 .....	314	1908 .....	325
1904 .....	661	1909 .....	232
1905 .....	746	1910 .....	204

Considering the increased population of the city, the decrease during the last four years is noteworthy.

Dr. Peirce, Pathologist, and Dr. D. Stewart, then a member of the House Staff of the Winnipeg General Hospital, in a paper prepared from a study of the records of the hospital, state that the records examined show that 30 per cent. of the cases of typhoid fever had been resident in the Province less than one year, and 49 per cent. less than two years. The average age of the cases admitted during the years 1896 to 1907 is given as 25.6, which will probably correspond very closely with the age of the majority of nurses and ward attendants.

Under these circumstances it is not surprising to learn that many members of the Nursing and House Staff were



affected. During the years mentioned (1901-10) forty-eight nurses and six physicians contracted the disease, although there was no trace of a house epidemic, except in the year 1907, when three nurses, two maids, and four physicians were taken sick with the disease between August the 18th and 29th. The source of the infection was not ascertained, although investigation was made, but it is supposed to have been due to the infection of some article of diet, probably milk.

In a report prepared for the House Committee and afterwards published in the journal of the Canadian Medical Association, Dr. Peirce brings out some interesting features regarding these forty-eight cases.

He finds that these nurses were on duty as follows:—

Medical side .....	37
Surgical ..	5
Unknown ..	6
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Total ..	48
First year .....	30
Second year .....	10
Third year .....	3
Graduates ..	2
Unknown ..	3
<hr/>	
Total ..	48

Two graduates contracted the disease during the epidemic of 1907, and one of the three in the third year was of doubtful diagnosis, so that about ninety per cent. of all the cases occurred during the first and second years of training.

If there is any one place in our communities where we expect to find stringent measures to avoid and prevent infection, one place where ample protection is given to inmates, it would be in a general hospital. So far most of our hospitals have been content to impress upon the nurses and employees sanitary and hygienic precautions, and even

this is done rather to avoid the carrying of infection from one patient to another than for the individual protection of the nurse or employee.

Dr. Richardson, Secretary of the Board of Health, Boston, points out that the incidence of typhoid in a hospital must not necessarily be taken as an indictment of the whole nursing staff, because the whole staff may be at the mercy of a single individual who is careless.

No matter how wise and clear the instructions may be, no matter how strict the regulations, it is difficult for the junior nurses and attendants to carry them out, or even properly appreciate the value of hygienic and sanitary precautions.

In the report already referred to Dr. Peirce says:—The question of protection that may be given to hospital nurses may be considered under two headings: 1. General Sanitation. 2. Immunization.

1. The fundamental principle underlying all typhoid sanitation is the fact that infection always takes place by way of the mouth. In "contact cases" infection is by way of typhoid germs transferred to the lips by the patient's own hands, which have been soiled by contact with infected material.

The pupil nurse should be, and doubtless is, instructed never to put anything in the mouth while on duty. This is made extremely difficult to the inexperienced nurse by the well-meaning acts of patients and their friends, who, finding that gratuities are refused buy the nurse with fruit and other delicacies.

Proper instruction, too, is given the pupil nurse as to cleansing the hands after coming in contact with typhoid cases, but it is scarcely to be expected that a recent recruit, bewildered by the multiplicity of details that she has to remember and tired often by the unaccustomed work, will unfailingly carry these instructions into effect. They are

of real use only after they have been transmuted into a habit, and this occurs only after she has passed out of the sphere of greatest danger.

A possible, though not very probable source of danger suggests itself. It has been shown that sewage flowing quietly in a smooth channel does not give off bacteria to the air, but if flowing in an irregular channel or disturbed in such a way as to produce bubbles which burst, minute droplets of fluid containing living bacteria may be given off and float about in the surrounding air. In this connection the noisy flush of the slop-hopper may be a source of danger to the nurse who has emptied imperfectly disinfected typhoid discharges into it.

These considerations emphasize the importance of keeping the inexperienced nurse away from contact with the typhoid cases. Whether this may be accomplished by segregating the typhoid cases and transferring the handling of the alvine and urinary discharges of such cases to a few experienced male or female nurses who have either had typhoid or who have been properly immunized against the disease, is a question for the management of the hospital to consider.

It seems scarcely to be expected, however, that sanitary measures alone will eliminate typhoid from the staff of institutions. Attention has therefore been given of late to methods of immunizing the individual in a manner similar to that which has met with so much success in smallpox.

Dr. Peirce's report recommended the adoption of anti-typhoid vaccination in the Winnipeg General Hospital. This recommendation was approved and although it was not made in any way compulsory two hundred and thirty-six treatments were given to ninety-four people, eighty-three nurses, members of the resident staff and others who applied for it, from June 24th till August 30th, 1911. It is too early to quote results, but it is gratifying to know that so far there has been no case of typhoid among the nurses.

*Method of administration:* The vaccine is injected subcutaneously at the insertion of the deltoid of the left arm, sterilizing the skin with alcohol and using a sterile sub-Q tuberculin syringe.

*Dose:* Three doses are given at intervals of ten days, the first dose is 0.25 cc, the second .5 cc, and the third 1.0 cc, giving respectively 500, 1000, 2000 million organisms.

*The reaction:* The pain is very slight and consists of nothing more than the prick of the needle. The local reaction in the greater number of cases is slight and consists of a red and tender area at the site of the injection, which persists for three or four days. In a few cases constitutional effects were noted and consisted of headache and rarely vomiting and diarrhoea. In only one case (in 94 persons inoculated) was the reaction so severe to incapacitate the nurse for work for a day. No skin infection was noted.

*Vaccine:* The vaccine used in the Winnipeg General Hospital consists of a culture on 2gar of the stock strain of B Typhosis, which has been in use in the laboratory for a number of years. This emulsified in normal salt solution, and the number of bacteria per cubic centimeter estimated by making plate cultures. The emulsion is sterilized by the addition of formalin in the proportion of 1-1000, and diluted so that 1 cc contains 2000,000.000 bacteria.

Although some doubt was cast on the efficiency of anti-typhoid vaccination by the reports of results obtained by the British Government during the Boer War, later reports have established its value as a prophylactic measure and it has been shown that the death rate from this disease among the unvaccinated in the British Army in India exceeded the total morbidity among those who had been vaccinated.

In view of these results it is now supposed that the vaccine used in South Africa had been injured to some extent by overheating in the sterilizing process. To avoid this danger Dr. Peirce has used formalin as a sterilizing agent with apparently satisfactory results.

In a paper written by Major Frederick F. Russell, of the United States Army Medical Corps, published in the journal of the American Public Health Association, he gives some statistics of the work in this line done in the English, American and German Armies, worthy of careful study, and adds:—

“It has now been sufficiently demonstrated that in anti-typhoid vaccine we have a simple, harmless and effective means of prophylaxis which can be used to supplement all the usual sanitary measures, and we believe it will materially help to reduce our morbidity and mortality, and place the army on a more effective and efficient basis.

These remarks apply equally well to the large army of hospital workers, and it would be interesting to know how many of our hospitals have arranged to give their nurses and staff the benefit of the protection it affords.

While there is yet much to learn as to the degree of immunity and the period for which it will last, the reports published are sufficiently favorable to justify every hospital in offering to vaccinate those members of its staff who come into close contact with the patients. Although at the present stage it could not be made compulsory, yet, if the conditions were explained and the opportunity offered, as it certainly should be, those interested will eagerly avail themselves of it.

PRESIDENT: We have two other papers this morning and we have to hurry our programme. We have with us a delegate from Public Health Service, Surgeon Austin. The marine hospitals of this country have treated a great many cases of typhoid fever, and I will ask Surgeon Austin to discuss this paper.



**DISCUSSION.**

**SURGEON AUSTIN:** I do not know that I will be able to say much that will be of special interest on this matter, except to say that so far as the Government service is concerned, they are utilizing the anti-typhoid serum in public service in the navy; it is used in the public health marine hospital service. We are offering it to all our patients, we cannot compel them to take it, but we believe that it is a very certain and safe preventive of typhoid fever when it is properly made, prepared and used. The statistics regarding the same warrant this Government in utilizing it in this way. My experience in the treatment of typhoid in hospitals has been a little difficulty from that of Mr. Cosgrave. I have never had very much difficulty in treating typhoid patients in general. I do not remember but one or two cases of typhoid fever breaking out in the wards in my own hospital. It is impossible to tell whether a man contracts his typhoid fever from a patient in the hospital. There are many ways in which a man might contract typhoid fever that could not be ascribed to poor nursing or contact with the patients in the ward. It is possible that he might get it from the water supply of a large city. Then the case of typhoid carriers is another very common way, I believe, in which typhoid fever is spread at times. It is a way in which a case is not known. It is in cases not known that typhoid may be spread in a hospital. I am rather inclined to believe that in some of these numerous cases referred to by Dr. Cosgrave that that means the cause of many cases occurring in a hospital, but in a city where there are a great many cases of typhoid, the fact that there are a good many similar cases of typhoid that develop in a hospital, is not absolute proof that it is due to an unsanitary hospital or poor nursing in that hospital, because the water supply is also, or may be, a source of infection, and that must be considered. But in the matter of the anti-typhoid vaccine, we feel that we have a means of preventing the spread of typhoid fever in our hospitals, if it is utilized and you can only make the public thoroughly believe in it. We have a remedy that will be most potent in preventing, not only typhoid fever in hospitals, but in the community generally. I believe that it is a certain preventive of typhoid fever where it is properly administered and a very safe remedy.

**DR. MORRILL:** I have had some experience with the vaccine, both in the navy and in the army. The only objection in any quarter to vaccine was to the nature of the reaction. In some cases it was severe, and in practically every case that we followed out in which



the reaction was so severe, it has been due to the use of a vaccine which was prepared from an improper strain of bacilli. I had it myself prepared from a pure strain of bacilli and I had a very nice reaction. From a report from the army we find that less than five per cent. of the men are on the sick list that had been treated with a pure strain of vaccine. We all know that when a regular soldier does not come up on a sick report when he is suspected he is not really badly off. I had charge of giving to not quite a thousand individuals about 3,500 doses, and I never have seen a reaction that lasted over twenty-four hours. I have seen them start within half an hour. I have seen men faint when the needle was inserted, and I have seen men faint just before they got up to the vaccine, but so far as actual reaction from the vaccine was concerned, I never saw that last over twenty-four hours, that is, from the army vaccine. As to the results, the most recent data on that subject is the report by Col. Keane, of the army, as to the results in San Antonio, Texas. The men that were vaccinated there were vaccinated under bad conditions. It was rainy, muddy, the men were living in tents, and there was every chance for their feeling badly from other causes, but the results of the sick report were something like this: Col. Keane had charge of the division hospital in the Spanish-American War, with a mean strength of about 10,000 men. They had 2,700 cases of typhoid and 200 deaths. At San Antonio, where all the men were vaccinated, there were 12,000 men in the camp, the same length of time, there was one case and no death, and this one case was so mild that it was diagnosed in the hospital as dysentery, and the correct diagnosis was not made until after the man was discharged from the hospital, which was seven days. They got a report of the blood culture after the man was well. I had a case of one man who had only his first dose; he was taken sick and he was only sick six days. The physician called me up to know what I could tell him about it, and I told him to get a blood culture as quickly as he could, because he had made up his mind the man did not have typhoid. He got a blood culture, and the blood culture showed positively that it was typhoid. The man was only sick six days and went back to work on the 19th, so that in this case the efficiency is very well demonstrated. But there is another error that we are likely to fall into—to think that the first dose of vaccine is protection. It is some protection, but not full protection. The importance of introducing this in our hospitals, making it voluntary, or at least urging it with our nurses and others coming in contact with the sick, cannot be overestimated.

DR. HASTINGS: Just one or two points I should like to draw attention to that I have not heard emphasized as much as I should like, and that is if all the intellect that is represented here, with combined effort, we emphasize two points only for the next twelve months, that we will do a tremendous lot to stamp out typhoid fever. The first is to emphasize to the public that it is a filth disease, and if you contract typhoid fever it means that you have taken some of the excretion of a typhoid patient in some way; therefore it is a filth disease, and by carrying out all the precautions which Dr. Richardson has presented to us in regard to contact precautions, that matter to a great extent, in addition to the food, can be eliminated. The most important point of all, if the United States or Canada were invaded by another country and we had them cornered up where they could not possibly get away, and then through carelessness on our part we would allow them to escape, we would deserve all that was coming to us after that. There is one place in the world that is a breeder of the typhoid germ, and that is the bed pan. If there is any plan by which we could get legislation, or any other means, to make it criminal to allow typhoid germs to escape from the bed pan, then we would be able to stamp out typhoid fever. I think if we will put all our efforts into that line for the next year, we would accomplish an enormous amount in stamping out this disease.

PRESIDENT: Mr. Cosgrave, have you anything to say in closing?

MR. COSGRAVE: Just one point in regard to the severity of reaction. In one case I might mention a nurse had the first dose without any result at all, the second dose was so severe, the result was so severe, as to lay her out for one week. That was the only severe reaction we had. Dr. Peirce, the pathologist, would not attempt to give her the third dose; he attempted to give her only about one-half the third dose, instead of the usual, but when the nurse came for it he happened to be absent, and the assistant gave the full dose without any result whatever.

PRESIDENT: The next paper is "The Foundation of Hospital Efficiency." In the absence of Mr. Firth, the paper will be read by Mr. Charles A. Gill.

## THE FOUNDATION OF HOSPITAL EFFICIENCY.

BY FRANK J. FIRTH, AN HONORARY MEMBER OF  
THE AMERICAN HOSPITAL ASSOCIATION.

Mr. President and Fellow-Members:—

What I am about to say to you is from the point of view of one who has for more than twenty-five years been an active member of the Board of Managers of a general hospital devoted to the free care of the sick and injured poor, and dependent for its support on the voluntary contributions of the charitably disposed residents of the district served. My subject is "*The Foundation of Hospital Efficiency*," and I feel sure you will agree with me that hospital efficiency, to be secure, must rest upon successful hospital finance. When such a permanent foundation has been created, the work of erecting and maintaining the necessary superstructure may be undertaken and carried on during the passing years with the enduring faith and effort that make failure impossible.

What I have to say will deal largely with hospital management and finance because of the controlling effect this combination has upon hospital efficiency. Success in hospital finance demands, as its minimum requirement, that expenses shall not be allowed to exceed available income. Please observe that I say expenses shall not be allowed to exceed available income, rather than that income shall not be allowed to fall below expenses. The one way of expressing it suggests, to my mind, economy in operation and the other a possible extravagance. Incurring obligations without any certainty of being able to meet them does not represent either successful finance or common honesty.

Charles Dickens, to whom the world owes so much, gave us as one of his immortal creations our interesting friend, Mr. Micawber. Does it not seem probable that among the numerous occupations of Mr. Micawber he must have had

some actual experience or a prophetic foresight as to hospital conditions? You remember the solemnity with which he conjures us to take warning by his fate and observe "that if a man had twenty pounds a year for his income, and spent nineteen pounds nineteen shillings and sixpence, he would be happy, but that if he spent twenty pounds one he would be miserable."

I will venture to say that there are few if any representatives of hospitals here present who cannot feelingly testify from their personal experience that Mr. Micawber was correct in his diagnosis of the conditions that produce hospital misery and consequent inefficiency.

I will further venture to say there are few of us who are able to assert, other than as a theory, that happiness in hospital management life follows the possession of a surplus of income over expenses. How many of us have had any such actual experience? A surplus!

Hospital efficiency of a high order must depend upon the possession of the funds necessary to meet the increasing calls that beset the ablest and most conservative management on every side, caused by the constant changes and advances in hospital standards, in order that the institution may in every department be kept abreast with the latest professional and other knowledge.

It is a fad of the day to talk about the unavoidable advance in the cost of living being responsible for every increased expenditure, personal or institutional, whether wise or foolish. An investigation recently made on behalf of a general hospital and covering a considerable period of years, demonstrated clearly that no important share of the large increase that had occurred in the current expenses of operation for the period, was due to increase in prices paid for wages or supplies. The fact is that both individuals and institutions are growing more and more extravagant in their modes of living and are demanding as necessities of life

many things that a few years ago would have been classed as representing only wasteful extravagance. It is almost literally true, however, that every advance made in hospital efficiency involves an increase in hospital expenses.

We may say of hospitals as John G. Saxe said "of all mankind":—

I classify the lot:—

Those who have money, and those who have not!

My profound sympathy goes out to those institutions that have it not. It is a wearing struggle to strive to maintain high standards of efficiency without the necessary means of support—to make bricks without straw! I have no desire to undervalue any of the many other considerations that are involved in the maintenance of a high order of hospital efficiency. I do desire, however, to emphasize the need for money as the commanding factor, the possession of which, when united with good management, stands for success.

In a general way observation and experience teach that the Board of Managers of an institution is, and should be, directly responsible for the securing and care of all needed capital and income and that, practically, the administration and not the Board is as directly, although not always so theoretically, responsible for current expenditures.

It is also a fact that although institutions differ radically in the work they undertake to do and in the sources from which they derive their income, they are far more nearly alike as to the need for many of their important expenditures than is popularly supposed: and as to many such expenditures, useful comparisons are possible between institutions almost totally different in their fields of labor. Their work may be general, special, educational or what not, but one and all involve the employment and care of men and women who must be paid wages and fed; they also all need medical and surgical supplies, and many other of their common requirements play an important part in their relative expense totals.



It has been said that the Board of Managers is directly responsible for the securing and care of all needed capital and income. This is the case whether the institution is wholly or partially endowed; or in receipt of income from patients for services rendered; or dependent wholly upon the voluntary contributions of the charitably disposed. Money does not come to any institution from any source in aid of any cause, however good, without intelligent thought and effort. The origin and direction of such thought and effort in hospital work rest with the Board of Managers.

Members of such Boards should not be chosen merely because of their ability and willingness to give money; still less because they are able to give, without knowing they are also willing. They should rather be chosen because of their recognized standing in the community as honorable, reliable gentlemen of proved ability, competent and willing to tell about the institution and its work to those who trust them and to frankly solicit the necessary aid for its support. It is the ability to make and hold for an institution many friends who can be relied upon to help in time of need that constitutes the really valuable asset of a hospital manager. No man should hesitate to ask his friends to be the friends of and contributors to his hospital for fear they may ask him in return to help some worthy charity in which they may chance to be interested. It is not altogether unusual to hear this reason given for a failure to seek support through personal appeal, which is the only reliable method.

Managers have many other important duties to perform in addition to the essential one of securing funds, and they should be fitted by experience to perform such duties. It is not every member of a board who is fitted to fill with credit the position of president, treasurer or secretary. Some of the members should be chosen with reference to the demands of these several positions. Good judgment is re-



quired on the part of the Board in the selection of the members of the administrative and of the professional staff. No good judgment, however, will secure for an institution the best administrative ability unless there is money available to pay the salaries such ability commands. No care in selection will command the services of the best type of professional men unless the institution is able to provide them with the modern equipment upon which professional success of the highest order so largely depends. Whichever way we turn we find successful finance appearing as an essential requisite in the attainment of the highest order of hospital efficiency. An important duty of the Board is to formulate and keep amended to date definite rules for the government of each officer and employee, professional or otherwise, so that all may work together, each clearly understanding his or her individual duty and united in a purpose to advance the standards of the institution they serve.

In their efforts to obtain funds a Board of Managers should have an intelligent understanding of the many ways in which other boards charged with similar responsibilities are striving to meet such responsibilities. The ways are numerous and often ingenious. The hospital with which I have long been identified depends wholly upon the voluntary contributions of the charitably disposed and among the many ways to which it has resorted to stimulate interest and obtain funds I may mention, in addition to the ordinary fetes, garden parties, donation days, hospital Saturdays for mill hands, children's play days on the hospital grounds, amateur theatrical performances, lectures, etc., etc., one or two efforts that appear to possess rather more of originality.

Auction sales of books autographed by their authors, the auctioneers being well-known residents of the locality with a reputation as humorous speakers, have brought in large returns.

A calendar starting with \$50 for the year; then \$25 for each of the four seasons; \$10 for each of the three months in each of the four seasons; \$5 for each week of the four weeks in each of the months; \$1 for each of the seven hours and 1 cent for each of the sixty minutes, yields about \$9,000 if successfully completed. Each party paying agrees to obtain those subscriptions immediately subsidiary to his own. This plan differs from the ordinary endless chain in that it has a specific, definite ending. Still another recent effort to stimulate interest has been through the distribution of a neatly gotten-up little book containing a true story of an accident experience in travel with its application to the hospital question.

The one policy no board may pursue and retain its self-respect is to sit still and do nothing in the presence of a financial emergency. It is the duty of every member to contribute his best thought and effort. All are not of equal capacity but each may do something, whether much or little. Honest purpose and persistent effort will often yield the greatest results where only the least were expected. It is the drone in the hive that is a positive drawback and injury to the workers. All should work. There is no room in the hospital world for drones by choice. Successful personal efforts of managers to interest the individual members of a district or community in contributing to the support of their local hospital service, creates an atmosphere of wholesome, unselfish thought for others that makes each individual life a happier and better one and the community a better place to live in. When individuals feel no interest in or desire to help their suffering neighbors, life becomes less worth living. In my own State of Pennsylvania I regret to say we have an objectionable system of state aid to privately owned and managed hospitals that discourages individual charitable effort in this direction and distinctly lowers the standards of good citizenship.

The needless multiplication of hospitals in a community is one of the causes for impairment of hospital revenues with a resulting lessening of efficiency. The creation of institutions that are likely to become a public charge through appeals to the general public, to the municipality or to the state for aid, should be rigidly controlled by law. A public necessity should be established to the satisfaction of some designated judicial body possibly advising with representatives of the nearby hospitals before such institutions should be allowed to come into existence.

There is another matter that has a direct bearing upon the relation of the managers toward the efficient working of the hospital they govern, and I refer to it with some hesitation, but its importance appears to forbid its being ignored. In the United States government service and in the service of many of the best managed of our commercial corporations it has become a custom to retire officers and employees on specified age limits. These limits are determined with reference to what experience has shown to be, on the average, the probable limit of ability to render efficient service. The custom sometimes operates harshly in that it retires men who are in apparent full health and vigor of mind and body, but on the other hand the great majority of those who are retired should be so relieved from active duties and responsibilities for their own best interest as well as that of the institution they serve. The practice has extended to the professional staff in the case of many of our hospitals. I believe the rule of retirement on the basis of a fixed age limit should, in a modified form, be extended to the managers of both commercial and charitable institutions. I say in a modified form because a Board of Managers acts not as separate individuals, as in the case of members of the administration and staff, but as a unit, and it may with advantage to the corporation be composed of men of differing ages. Individuals must grow old and pass away, but a properly constituted board should

never be allowed to grow old. It should always represent the wisdom and experience of those of mature years with the energy, courageous initiative and ready adaptability of the younger minds. I venture to suggest that in hospital practice the basis age limit for members of the Board of Managers might with benefit to all concerned be made seventy years, and that not more than one-fifth of the total board membership should at any time exceed this limit, the senior member of the fifth retiring from the Board when the passing of time adds another to the limited list. No member of the Board should continue in any of its executive positions, that is, president, vice-president, secretary or treasurer after arriving at the fixed age limit. Members who retire on age should be eligible for immediate election to an honorary advisory board or committee. Membership in such a body would represent a just recognition of useful service, and it would also insure retaining for the institution the advice and counsel of its ex-members that their expenditure should have made them exceptionally competent to afford.

An age limit retiring plan, to be of any practical value, must be permanent, self-acting and permit of no exceptions in its operation. The plan should be adopted by the corporation at an annual meeting and changed or amended only by the corporation at a future annual meeting upon due public notice in advance of the exact change or amendment that is to be presented for consideration by the meeting. The Board should have no discretion to interfere in any way with the automatic operation of the plan.

Concluding my remarks upon this portion of our subject, I unhesitatingly affirm that success in securing funds demands intelligent care in the selection of members of the Board of Managers; a worthy cause; a personal knowledge of its merits and an inspiring faith; with personal heart-to-heart, soul-to-soul appeals and a determination to succeed that cannot be successfully resisted. Such conscientious effort commends success because it deserves to succeed.

Napoleon once said, "I hold that one bad general is worth more than two good ones." A much higher authority said that no man can serve two masters. An efficient administration must have but one recognized head. In hospital practice this head is ordinarily the superintendent. He is the chief resident executive and acts with the powers committed to him by the Board. This chief executive and his subordinates constitute the administration hereinbefore said to be directly, although not always theoretically, responsible for the control of current expenditures and for the economy or the extravagance with which the institution is operated. The superintendent should pass upon all requisitions for men or material, both as to quantity and quality. He should determine under established rules, where such exist, from whom and at what prices articles needed are to be purchased. It should be in his power to decline to fill requisitions from his subordinates, professional or otherwise, for what he deems to be unnecessary quantities or needlessly costly supplies of every sort. He should procure such competitive offers of standardized material as will make it certain that he obtains the best governing prices. In the employment of such subordinates as he may at his discretion employ and fix the pay of, he should always keep his expenses down to the lowest scale consistent with a proper standard of efficiency. A careful, economical, not parsimonious, superintendent will influence each of his subordinates to pursue a like course of thought and action, making needless demands few in number.

A hospital may fortunately possess an exceptionally able and economical superintendent, but no hospital will by any chance escape from the certainty that its methods and economies may be improved by comparison and exchange of experiences with other hospitals. There is no man so wise that he cannot learn something from every other man with whom he comes in contact. It is a law of life that, as has been said, by exchanging experiences we each learn some-



thing. We hear a great deal of late about scientific management, and it has become a recognized branch of the engineering profession to undertake the investigation and the outlining of an economical working organization and methods for important manufacturing and other industrial works. Great economies and advances in standards of efficiency have resulted from intelligent effort of this description.

The hospital service has made some movement in this direction. You all know, I have no doubt, that certain of the important New York City hospitals have united in an effort to standardize the materials needed in carrying on their work and to obtain the best possible prices thereon by contracting through a common agency for their purchase in large quantities upon the basis of competitive bids. Each interested hospital orders its own supplies on these contracts as needed. This effort is of comparatively recent date but it merits a success that I hope and believe it will eventually achieve.

There is another and simpler direction in which united effort may result in advancing hospital standards of economy and efficiency. As the result of some investigation I venture to recommend the formation of temporary local groups of hospitals, each hospital to agree to unite with the others in employing a competent expert to visit the several hospitals in the group in rotation and thoroughly investigate their method of management that affect their current expense of operation and maintenance. After becoming familiar with the methods of each hospital in the group, the expert should again make the round of them all with reference to determining from their combined experience what would appear to be the best practice for each of them, then recommending to each Board of Managers the changes that seem desirable in order to attain the best results in the institution it represents. This does not contemplate revealing the practices and weaknesses of any one



hospital to any other, the thought of which appears at times to have almost created a hospital panic, but it does purpose making available for each the best possessed by all.

It may interest you to hear about one or two co-operative, comparative efforts of which I have personal knowledge. Soon after the formation of the Philadelphia Hospital Association, a committee was appointed to investigate and report upon the comparative cost to the different hospitals of one important expense item. The report was made and it proved to be both interesting and valuable. The chairman of the Executive Committee of one of the important hospitals told me some time afterwards that the comparative information given by that report had enabled his hospital to make a saving of three thousand dollars a year in their expense account.

On another occasion a group of about six hospital presidents agreed to exchange information as to prices paid for fifteen or twenty of the staple articles of consumption. A considerable difference in prices was developed. It was so important as to a few of the leading articles that a detailed investigation followed and it was then discovered that the bases of the comparisons were not exactly alike in all cases and so a number of the comparisons were practically worthless. In some cases the prices were based on a delivery at the hospital, while in the case of a suburban hospital they were based on delivery at the store where they were purchased, the hospital doing the hauling. Various differences appeared in the qualities as affecting market values, and in other cases the same articles were found masquerading under entirely different trade marks. It was only after considerable effort that a common basis of comparison was arrived at that yielded valuable practical results. I refer to this case to emphasize the need for disinterested expert work in order that reported results shall be of the greatest possible practical value. Few hospital presidents are ex-

perts and few superintendents would find themselves equal to a judicial condemnation of methods they had allowed themselves to believe were the best in use anywhere!

In conclusion and summing up all that has gone before, I may say:—

I. The highest standards of hospital efficiency demand successful hospital finance.

II. The members of the Board of Managers should be chosen with reference to their ability and willingness to render efficient service and to retire when unable to fill their positions with credit.

III. The Board should recognize as its most important work, individual and collective, the securing the funds needed to carry on the work of the institution on a high order of efficiency, at the same time enforcing a judicious economy in all expenditures.

IV. The Board should learn from the experience of other institutions the best methods of obtaining and of expending money so that each dollar spent shall yield the largest return possible.

V. The administration and staff should recognize the importance of their making no unnecessary calls for men or material, but should use their best effort to keep their several departments abreast with the highest standards of efficiency both as to the quality of their results and the economy with which they are secured.

It is ours to make of money a useful servant, never allowing it to become our master. Money!!

"The friend of wrong, the equal friend of right,  
Oft may we bless and oft deplore his might,  
As buoyant hope or darkening fears prevail,  
And good or evil turns the moral scale."

Before we part I would like to add a word about a detail in dispensary practice. When patients with defective vision visit an eye dispensary, their eyes are examined,

tested and a prescription is given them for proper aids to sight—glasses. When patients visit an ear dispensary they are examined and treated, but I know of no provision anywhere for prescribing aids to hearing. Why should patients be sent away with no help given them in this most important particular? I know this class of service takes time, but so does all really good work. The whole dispensary atmosphere has impressed me as being one of a hurry that is not suggestive of the best results. The ear dispensary of one general hospital was equipped with eight or ten standard aids to hearing, and the physicians in charge were encouraged to test patients having defective hearing and to prescribe the particular aid best suited to each case. After some time one of the young residents working in the ear dispensary was asked how the plan worked out practically, and while it developed that no valuable effort had been made to prescribe the aids, the resident said those on hand as samples had been useful in communicating with the partially deaf patients! I believe this subject presents a possibility of a valuable advance in the practical efficiency of our ear dispensaries and commend it to your consideration.

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PRESENT DAY METHODS OF GIVING  
ANÆSTHETICS IN HOSPITALS.

DR. WILLIS G. NEALLY,

*Assistant Superintendent New York Hospital,  
New York City.*

It is only within comparatively recent years that much attention has been given to the administering of anæsthetics in hospitals, it having been previously looked upon as such a minor part of the surgical work that it was done by anyone available.

The trustees of hospitals and the medical profession are being gradually convinced that this part of the surgical work should be in the hands of specialists, or those having some special training in this branch.

On account of the constant changing of internes, who give the anæsthetics, through advancement, illness, etc., and the filling of their places by men less experienced than themselves in its administration, many hospitals are employing specialists, either physicians or graduate nurses, trained for this special work.

Last April circular letters were sent out by the New York Hospital to numerous hospitals in this country and abroad, inquiring as to their system of administering anæsthetics, and it may be of interest to this Association to learn the results of the investigation.

There were 55 hospitals heard from in this country, including Canada, with the following classification:—

Nurse anæsthetists with salary and maintenance, \$300—\$1,200 a year. 14, or 25%.

Resident physicians (including 2 women). Salary \$600—\$1,800 a year. 6, or 11%.

Salaried specialists (physicians) without maintenance, requiring their presence for a few hours each day. Salary \$600—\$1,000 a year. 5, or 9%.

Instructors without salary, but who receive fees from private patients. (Internes administering the ether to ward patients), 5, or 9%.

Instructors with salary \$100—\$700 a year, who come to the hospital for a few days or weeks at the beginning of interne's service, 5, or 9%.

Instructors without salary, 6, or 11%.

There were 7 foreign hospitals heard from—4 in England, 3 in Germany, and 1 in France.

In the English hospitals some members of the medical staff who are experts in administering anæsthetics are appointed honorary anæsthetists. In addition there are so-called assistant anæsthetists with salaries of \$125—\$600 and maintenance. These specialists give the anæsthetics in difficult cases and instruct the internes who give most of the anæsthetics after they have duly qualified.

In Germany, the internes, licensed physicians, administer the anæsthetics.

In the single French hospital heard from the internes give the anæsthetics.

It will be seen that over 25 per cent. of the hospitals heard from in this country employ nurses as anæsthetists. They do not do all the anæsthetizing but instruct the internes and have general supervision of this branch. They take charge of the anæsthetics and supplies, with a marked decrease in the amount used.

In many institutions they assist in the general work of the operating room and take entire charge of the instruments. They do not aspire to be surgeons or assistant surgeons, therefore, they give their undivided attention to administering anæsthetic, consequently many of them become very expert in this line. From practically all of the hospitals come very favorable reports of this system.

Many hospitals were found to be contemplating the employment of nurses for this work.

Where a resident physician is employed as anæsthetist, the interne in the majority of cases gives the anæsthetic under the supervision of the specialist, the latter giving the anæsthetic in difficult cases. This system was found satisfactory.

In the hospitals employing salaried specialists (physicians) without maintenance, their presence being required but a few hours each day, according to the number of operations, most of the anæsthetizing is done by them. They also instruct the internes who anæsthetize the minor cases and the few occurring during the night.

In the hospitals where the internes give the anæsthetic, without direct supervision, the specialist coming to the hospital for only a few days at the beginning of the interne's service, much dissatisfaction was expressed and quite a few hospitals contemplate employing nurses as anæsthetists.

In fully 90 per cent. of the hospitals the junior interne gives the anæsthetic. He usually considers this part of his hospital training, after a short period, as drudgery and consequently is only too willing to turn it over to even a less experienced man. He soon vacates the position and another untrained man takes it.

This frequent substituting of unskilled men is bound to be harmful to the patients and a source of annoyance to the operator.

A serious objection to the interne anæsthetist is, that he does not confine his attention wholly to the anæsthesia, but will very often be found spending much of his time watching the operation. He considers it his right and privilege to see all that is going on, for after all, is not that *why* he sought the appointment.

There are but few medical schools in this country that give any practical training in the administering of anæsthetics, one or two lectures comprise the ordinary course.

In England by a regulation of the General Medical Council all medical students are taught to administer anæsthetics.

Evidently the medical schools of this country leave, practically, all the teaching of this important branch to the hospital, which is all the more reason why the interne should have as good training in this, as well as along any other line of medicine.



When the interne graduates from his hospital and goes out into practice—especially in country practice—not a little of his income for a few years will be derived from administering anæsthetics, consequently it is desirable that he be well-trained in this line.

In some States it is illegal for a nurse to give an anæsthetic, and it is a question if it is legal in many States, New York included, for a nurse or anyone, not a licensed physician to do so.

If the anæsthetist were not a licensed practitioner responsibility in case of fatality would rest, from a civic standpoint, upon the individual giving the anæsthetic, and upon the corporation employing him, and also upon the licensed practitioner under whose direction the anæsthetic was administered.

Under the German law only licensed practitioners are allowed to administer anæsthetics. In the English hospitals nurses are never allowed to administer the anæsthetic.

The majority of patients dread the anæsthetic, as much if not more than the operation, especially those who have previously taken an anæsthetic and had the misfortune to be "smothered."

In every hospital the patient should be the central figure and the institution conducted for him. He has a right to expect and demand the most skillful treatment the attending physicians, staff, nurses and hospital as a whole can offer, and certainly the administering of an anæsthetic is an important part of the surgical work.

Patients are beginning to realize the danger to which they have been and are being exposed. They will soon learn to go to the hospital where the anæsthetic is given with the utmost precautions for their safety. They will no longer allow any inexperienced person who "happens around" to administer to them a powerful drug about which he knows little or nothing.

Those of you who have taken an anæsthetic will probably remember with what care you selected the anæsthetist as well as the operator.

Certainly this dangerous and inexcusable system of allowing junior internes to do this important work, without direct supervision, should be abandoned.

If it is legal for a nurse to administer an anæsthetic under the direction of a surgeon, it would seem from every point of view that this is the best system.

It has been proven that she is efficient and economical. When not anæsthetizing she can be useful in many ways in the operating room or about the hospital.

She should be a graduate nurse, trained in giving anæsthetics, and should reside in the hospital. She should administer the anæsthetic in difficult cases and instruct the internes who should give the anæsthetic after duly qualifying.

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#### DISCUSSION.

DR. DREW: I should be sorry to see this paper pass without a full and free discussion. It seems to me a very important matter, and I should like to hear from those hospitals where they have the nurse giving the anæsthetics, to know what the legal standing is, whether the hospital would be any more responsible for an accident which would happen if a nurse was giving the anæsthetic than a graduate in medicine, whether the diploma granted to a physician gives him the legal right to administer an anæsthetic. I know that in many hospitals nurses have been giving anæsthetics for years, and I do not know that the matter has been decided in the courts.

PRESIDENT: In our own hospital we have in the last two years engaged a woman physician as chief anæsthetizer, pay her \$600 a year, and she has the teaching of the house staff. Our house staff comes on the first of June and she spends the greater part of two months in teaching that house staff the proper administration of anæsthetics. We have done very well since we made that move, and think that we have partially solved the problem of administration of anæsthetics in our hospital. When this woman physician leaves us, I do not know what we will do, we will make an attempt at least to get another. This is a very important subject.

DR. A. M. SEABROOK (Woman's Hospital, Philadelphia): In the Woman's Hospital at Philadelphia, we have had for five years a woman physician giving anæsthetics. She gives it to the private patients who are operated on and she instructs the internes. We have found it most satisfactory.

MISS H. HARTY (Minneapolis): When his subject came up in Toronto some three or four years ago, I remember that in Minneapolis they had just appointed a nurse to give the anæsthetics. That nurse is still giving anæsthetics and has given between four and five thousand, with but one death, and we believe that was due to the fact that the surgeon insisted on the nurse giving chloroform, when in her judgment (and in the judgment of the house physician) she should have given ether.

DR. P. E. TRUESDALE (Fall River): About six years ago I visited the Mayo clinic at Rochester, Minn., and there I witnessed the administration of the anæsthetic, ether, by Miss McGaw. It was the smoothest etherization that I have ever seen. She was a graduate nurse, and had been giving ether as an anæsthetic in 10,000 cases. Surely climate had nothing to do with her success. If it could be done at Rochester, Minn., it could be done in other cities. Since that time I have had a nurse administering anæsthetic ether in almost every case, with the utmost satisfaction. The nurse, if she has a good intellect, will devote her entire time and study to the anæsthesia. She will get along without a hypodermic syringe or without the use of oxygen. I consider that in the administration of the anæsthetic there is no more dangerous instrument than the hypodermic needle in the hands of the anæsthetist used for the purpose of stimulation. I wish to add my testimony in favor of the graduate nurse selected for the administration of the anæsthesia.

MR. C. E. STRASSER (Brooklyn): In referring to this subject, I want to say that in the European hospitals female nurses, as well as male nurses, who become graduates, were taught how to give anæsthetics in the War of 1871. Only the nurses gave anæsthesias in the ambulatory hospitals on the field.

MISS AYRE: Shall we give pupil nurses training in administering anæsthetics? If not, how is the graduate nurse to obtain instruction afterwards?

DR. W. O. MANN: I have an idea that our nurses are given some instructions by a woman physician who looks after anæsthesia. She also instructs the internes and then the junior internes do as the doctor says. I have frequently been in the operating room and seen women giving ether. I think a pupil nurse should be instructed. She has to go out into the country and has to assist a country doctor and she ought to know how to handle the ether bottle.

Adjourned to 2.30 p.m. same day.

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WEDNESDAY AFTERNOON SESSION—SEPT 20.  
DIRECTORS' AND TRUSTEES' SESSION.

PRESIDENT: Many of you have been visiting the private hospitals of the city. Do not forget New York has many city hospitals well worth visiting, and we have an invitation from the Commissioner of Charities to visit all those hospitals.

The Secretary read the invitation.

PRESIDENT: We have arranged for this afternoon a Trustees' and Directors' session. Mr. Henry S. Van Duzer, of the Presbyterian Hospital of this city, and a member of the Board of Managers, has consented to act as chairman of this session. I take pleasure in introducing Mr. Van Duzer.

CHAIRMAN VAN DUZER: Mr. President and Members of the Hospital Association:—First of all I want to express my deep appreciation of your kind request that I preside at this afternoon session, and also the pleasure and gratification that I have felt in meeting so many of the superintendents of the hospitals here and in Canada and also members of the Board of Directors of the different hospitals. It gives me a new incentive in my work to talk with so many that are interested in this great work, not only the care of the sick, but the advancement of medical and surgical science, and I think that most of you believe that it is well you should try to excite a greater interest among trustees. It has been my pleasure to visit almost all the hospitals in this city and many throughout the country and abroad. I never visit them that I do not find there is something new and something better and something gained by consultation with those who have given their lifetime to this work. So when we take up the subject this afternoon of the standardization of hospital requirements and a central purchasing bureau, it is not alone an economic question.

The coming together of the men of the hospitals, the superintendents and assistant superintendents and telling their experience, showing up what they think will be best, that brings a standard which the best experts in hospital work feel it is best to adopt; and then when adopted, the economic question comes in that those articles can be purchased at very much less than the individual can purchase them. The hospitals that are well endowed can experiment in finding what is best, and give all others the benefit of it. Now, it is not the duty of your presiding officer to discuss these questions that are coming up, but it is his pleasure and your pleasure to hear those who have kindly consented to explain the numerous questions that they are especially interested in. The first subject that comes before this meeting, is "Hospital Facilities in New York City." If there is any one man in this city that knows more about it than the gentleman who is to address you this afternoon, or has given more time and attention to that subject, I do not know of him. So I introduce to you Mr. Hebbard, Secretary of the Board of Charities of the State.

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## HOSPITAL FACILITIES IN NEW YORK CITY.

BY MR. R. W. HEBBARD.

Mr. Chairman, Ladies, and Gentlemen:—

The City of New York, which has been honored by being chosen as the place of this important meeting, is now one of the greatest communities in the world and is destined soon to become its largest city. In view of these facts it is clearly apparent that New York City not only owes it to itself to be at the very forefront in all good works, but that it owes to the other cities of the world the duty of setting a good example, the duty of holding high the lamp of knowledge so that they may be guided in their civic work by its reflection. This is particularly true with relation to those social movements designed for the betterment of mankind, and especially for the care of the helpless and the unfortunate. In order that conditions may improve and progress be made, it is necessary for us to study not so much those things in which possibly we may chance to excel, but rather those matters wherein we show defects, and in this spirit and with this purpose in view it is my intention to address you briefly this afternoon on the subject of the "Hospital Facilities in New York City."

For many, many years these facilities have been most inadequate and they still are entirely inadequate to the present pressing needs of the city, leaving entirely alone any consideration of the requirements of the near future. It is in fact only within very recent years that any determined effort has been put forth toward bringing the public hospital facilities of the city up to anything approaching a proper standard. The present and the last previous city administrations have probably made more progress in the right direction than those that went before them for a full quarter of a century. The present Mayor, like his predecessor, is, I am confident, most anxious to have his administration set a shining example in this respect, and he evidently

appreciates the necessity of generous action on the part of the fiscal authorities of the city in order to bring about the desired results. Former Comptroller Metz, as well as Comptroller Prendergast, who is now the head of the City's Department of Finance, have also been possessed of a right and progressive spirit with relation to this important subject. To the great credit of the present members of the Board of Estimate and Apportionment be it said, that such Board has recently appropriated nearly \$3,000,000 for the upbuilding and general improvement of the facilities of the hospitals and other institutions of the Department of Public Charities, the Department that has most of the city's public hospital work to do.

In 1906, Mayor McClellan having come to realize the exceedingly illogical character of public hospital administration in the City of New York, appointed a commission composed of eminent and informed citizens to study the subject of public hospital administration in the City of New York and to prepare a report with respect to such system including recommendations for its improvement. This commission gave close and earnest consideration to the subject. It secured information from the best and most reliable sources here and abroad. Its report, with the testimony taken, is published in a bound volume, with suitable index, of over 750 pages.

The Commission reported at the end of its labors that the three different departments of the city government that administered the public hospitals of the city carried on their work without any definite basis of co-operation between them. These are the Department of Public Charities, the Department of Health, and the Trustees of Bellevue and Allied Hospitals. It came to the conclusion and recommended to the Mayor that the management of the public hospitals of the city be consolidated in a single department under the management of a board of trustees, which should appoint an executive officer to carry on the work under the

general direction of the Board. No progress has been made, however, towards carrying out this recommendation, mainly for the reason that not one of the departments named has seemed to be willing, even in the interests of the common good, to give up a single institution to a central board such as was proposed by Mayor McClellan's Commission.

Largely owing to this complicated system of management, as it would seem, practically no plans had been adopted up to 1906, aside from those being carried out slowly by the trustees of Bellevue and Allied Hospitals, for the general and systematic improvement of the hospital facilities of the city. This was the case notwithstanding the fact that there was necessarily a constant increase, an increase as sure and as certain as the rise and fall of the tide in the harbor of the city, presumably of not less than 500 additional patients a year in the number to be cared for in such institutions.

Although Blackwell's Island is one of the most valuable and useful public hospital properties in the world, no survey had been made of it, or of any of the other hospital properties of the Department of Public Charities. No layouts had been prepared for the extension of the buildings, no landscape plans had been made for the grounds, and despite the clearly evident needs of the future, there was a general lack of system for the extension of the facilities of the department. But in these respects there has been a change for the better. The surveys have been made and the general plans are ready, and the appropriation of sufficient means to carry out the plans is the next essential step toward meeting the requirements of the situation. It will be necessary for the City of New York to spend millions of dollars and to prosecute the work of construction much more rapidly in the future than ever before in the past before it is in a position to take proper care of the patients that clamor at the doors of the public hospitals for relief, much less set that good example which it is its duty as a great and progressive city to set to the other cities of the world.

The plans of this department, and I speak principally of them because, as I said at the outset, it is the great hospital department of the city caring probably for three times as many patients daily as the other hospital departments combined, contemplate that Blackwell's Island, which is readily accessible from every borough, shall eventually become a great hospital park for the care mainly of the adult sick poor and the thousands of friends who visit them, that Randall's Island shall be made into a hospital park for sick children and their friends, that the Kings County Hospital property shall be dealt with along similar lines, and that the relatively able-bodied poor from the city homes on Blackwell's Island and Flatbush, who, instead of the sick, are really the ones to be cared for by the department, shall be maintained at the Farm Colony on Staten Island where they may be given plenty of suitable labor suited to their strength and capacity.

Not only has the extension of the facilities of the department been slow, but the poorly paid hospital helper system has been the cause of much inefficiency and grievous complaint. Four excellent training schools for nurses supply the pupil and the graduate nurses necessary for the work and are bright and shining lights in the administration of the department. But much of the work of caring for patients is carried on by the hospital helpers, nearly a thousand of whom receive less than fifty cents a day and their maintenance. This service shows constant change over 8,000 changes having been made in it in a single recent year because of the general inefficiency of those employed for such service. Liberally increased means will have to be forthcoming in the annual budget of the department before the evils of this superficially cheap but really expensive service in the public hospitals of the city can be remedied. Commissioners and social workers have urged this reform for years, but the evil still continues practically unabated.

Under the divided responsibility of management and control of the public hospitals such as I have pointed out in this city, it is but small wonder that such hospital system has grown and flourished only in spots. During recent years plans calling for the expenditure of not less than \$12,000,000 have been authorized for new general public hospital facilities in the Borough of Manhattan, and are being systematically carried out, while less than a quarter of this amount has been authorized for the same purpose for all the other boroughs of the city. During recent years also the wages of the hospital helpers in the service of Bellevue and Allied Hospitals have been materially increased, with the result of improving the service, while those in the hospitals of the Department of Public Charities, with its injurious almshouse connections, have remained at much lower rates.

Under such divided responsibility it is also small wonder that the facilities of the Health Department Hospitals are so inadequate during those seasons of the year when the forms of diseases treated by such hospitals are most prevalent.

It is but a few years ago—and in the interim there has been but little increase in facilities—that a Commissioner of Health publicly admitted when interviewed by a reporter on the subject, that they had as many as six patients in one bed in a children's department of one of the Health Department hospitals. How long do you suppose such conditions would continue if the Health Department itself had not been conducting the hospitals? Personally, I do not believe that there is any more necessity for the administration of hospitals for the treatment of the ordinary contagious diseases by the Health Department, than there is for the administration of the prisons by the city magistrates or by the police authorities, and as the McClellan Hospital Commission pointed out, the city should no more have three public hospital departments doing its work than



it should have three fire departments for preventing fire or three police departments for preserving the peace. But I go a step further and contend that there are more reasons for a unified hospital control than there are for unification of the fire and the police departments. From Bellevue to the Island hospitals of the Department of Public Charities, there is a constant transfer of chronic patients in order that the wards of Bellevue may very properly be left free for the treatment of acute and emergent cases. For years this transfer system, involving thousands of the most unfortunate of God's creatures, has been the source of much friction. The failure to receive such patients in the Island hospitals has caused congestion in the Bellevue wards, and has retarded the important work of that institution. The greater the growth of the new Bellevue and the larger the number of patients received there, the greater will become the necessity for the more rapid extension of the facilities of the Island hospitals, but as a matter of fact the facilities of the general hospitals on the Islands are not being extended. In order that these facilities should be co-ordinate-ly extended it is highly desirable, if not actually necessary, that there should be a unified public hospital system covering all portions of the city and able to carry out its plans and purposes throughout the entire system under its control.

The City of New York contracts with some 65 or more private hospitals for the care of emergency patients at a stated per capita rate, but the inspections of the State Board of Charities show that nearly all of these institutions have been at times, like the department's own hospitals, greatly overcrowded. So many instances of insufficient air space allowed to patients have been discovered in these private hospitals having contractual relations with the city that the Board has been obliged to establish air space requirements which have necessarily been made most conservative in order to prevent the large amount of suffering through the exclusion of patients, which would have followed the adoption of more radical provisions.



Besides the private hospitals that have contractual relations with the City of New York, a number of the larger private hospitals such as the New York, the Presbyterian, Roosevelt, and St. Luke's, do a vast amount of work for the poor as well as those who are able to pay, and thereby help to relieve a situation of long-continued public indifference and neglect that would become a burning scandal without the co-operation and assistance of the private hospitals, whether such assistance is freely or otherwise given.

The ambulance service of the city has for years been unsatisfactory and the cause of much complaint. There is at present a definite plan for its official supervision and improvement, which it is hoped, may prove successful.

While Boston has a well-equipped emergency relief and ambulance station in its business section, New York City has in the lower part of Manhattan, which at any time may be visited by a casualty of the most serious character, no public relief station or ambulance, but relies to a large extent upon the crude and entirely inadequate facilities provided by the religious organization known as the "Volunteers of America." This is, however, but an example of the general lack of facilities that prevails in every part of the city.

To sum the whole matter up concisely, New York City is about a generation behind the age in its public hospital and ambulance facilities. To bring it up to date it urgently requires a unified hospital and ambulance administration in order that the needs of the situation may have that careful and comprehensive consideration that is essential to equitable judgment, and it requires the appropriation annually for a long period of large means for the proper extension of its public hospital facilities for the care of both acute and chronic cases, as well as the extension of its emergency relief station and ambulance work if it is to meet the needs of the future in a manner at all becoming such a great and wealthy and generous city.

The demand is for a public hospital system that shall be in all respects honest and efficient, scientific and up to date, and above all things, gloriously humane from beginning to end.

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## PURCHASING BY A CENTRAL BODY VS. BY SEPARATE INSTITUTIONS.

BY MR. HENRY C. WRIGHT,  
*Russell Sage Foundation, New York City.*

In this paper I shall endeavor to point out some of the advantages and disadvantages connected with the collective, or joint purchasing, of supplies for the use of public institutions. The officers of every large institution, and the officers of every State, have no doubt frequently asked the question, whether they were buying their supplies as cheaply as possible, or in the most advantageous manner, considering the general welfare of the institutions.

It is difficult to answer such a question as applied to any section in an absolutely conclusive manner. I believe it possible, however, to gather sufficient facts to arrive at a conclusion on which it is safe to act. The greater portion of the investigation carried on by the writer about a year ago, in the institutions of New York State, Indiana, and Iowa, was directed toward answering this question, and, on the basis of the facts collected, conclusions were reached and recommendations made. In this paper, I shall attempt to discuss the question in a somewhat more detailed manner than in the report of that investigation, and set forth somewhat more fully the reasons for the conclusions reached.

### CAN SUPPLIES BE PURCHASED MORE CHEAPLY WHEN PUR- CHASED JOINTLY THAN WHEN PURCHASED BY ONE INSTITUTION.

Let us first ask the question whether supplies can be purchased more cheaply if purchased in large quantities than in somewhat smaller quantities; or more cheaply if the supplies for several institutions be purchased at one time rather than each institution purchasing its supplies separately? Into the cost of an article purchased by an institution enters several variable factors, which may be considered separately. First is the sale price of jobbing house from which the article is purchased; second, the cost of

handling and cartage; third, freight or express. Will jobbing houses sell supplies cheaper in quantities demanded by, say, ten or more institutions, than in a quantity required by one institution? Inasmuch as no one jobbing house handles all lines of supplies used by one institution, we must attempt to answer this question as applied to the various lines. Different manufacturers or different trades have different jobbing or selling methods. For instance, it is a general custom in the cotton goods trade for the manufacturer, through a sales agent, to sell to a jobber at a certain price less a certain discount, and when the jobber sells to the retailer, he sells at the list price of the manufacturer and makes as his profit the discount allowed by the manufacturer. This has become the general practice in the cotton goods trade, and the same discount is given by a jobbing house whether one case or a carload of goods is purchased. Likewise, when a jobbing house sells to a retailer, he sells at the same price whether he sells in small or large quantities. So, one institution can purchase cotton cloth as cheaply as it can be purchased were a contract let for the supply of the institutions of the entire State. I think this was fairly conclusively proven by comparing the cotton goods purchased by the Rome State Custodial School and Training School for Girls at Hudson in the State of New York, with the prices secured by the purchasing committee of the Lunacy Department who contracted for the same class of goods for all of the insane hospitals in the State. Samples of goods were obtained from the two institutions referred to which bought their supplies separately and compared by an expert in New York with a like class of goods purchased under the contract entered into by the purchasing committee of the Lunacy Commission, and it was found that these two institutions had purchased their gingham, cheviot, bleached and unbleached muslins, khaki cloth, etc., as cheaply as had the Lunacy Commission. In New York State each prison purchases its own supplies, and

the prices paid for some supplies by the Matteawan Hospital for the Criminal Insane were compared with the joint contract prices of the Rochester Insane Hospital and the Rome State Custodial Asylum. It was found, on an average, that Matteawan purchased supplies practically as cheaply as did the other two institutions. A comparison was made of the prices paid by the institutions in Indiana with those paid by the State Board of Control in Iowa, and by the purchasing committees in New York, and it was found that the Indiana institutions, purchasing separately, secured on an average as low prices as was secured in Iowa or in New York State. While in Indianapolis, I noted that one or two of the large grocery jobbing houses did not furnish any of the supplies of the institutions in the neighborhood of that city. I went to the chief officer of two of these houses and asked how it came that they were not furnishing any of the supplies, whether they had bid and had not secured the contract, or whether they were not attempting to secure the patronage of the state institutions. In both cases I was told that other jobbing houses were willing to do business upon a four or five per cent. profit with these institutions, but these jobbing houses with which I was conferring, did not care to do business upon that small margin and consequently had ceased to send in bids, as they had done in former years. This seemed again to confirm what we had apparently discovered by a comparison of the figures of the three States—that the separate institutions in Indiana were securing their supplies not only at a low jobbing price, but at a lower percentage of profit to the jobber than he secured in selling to the retail merchants. I consulted with one of the leading grocery jobbing-houses in Chicago and asked whether they would make better prices on a large contract for goods of an amount that might be used by the institutions of an entire State than they would give to one institution purchasing separately. They said they would make no difference in the smaller or larger

amounts, inasmuch as the delivery of supplies would have to be made to many different places and at many different times. The jobbing houses in New York were likewise consulted, and one stated that they would sell at a cheaper price in a large contract quantity than to separate institutions, while another jobbing house was non-committal; and a third one claimed to give as low a price to the separate institutions as to several institutions combined.

The second variable that enters into the cost is handling and cartage. If a jobbing house could contract for a large amount of supplies, and make large shipments at one time, to one destination, such a house probably could afford to give a somewhat less price upon a large quantity than upon the smaller quantity used by one institution; but since institutions are located in various parts of the state, and want their supplies at various and irregular times, the jobbing house is required to make shipments in as small quantities and as irregularly as though each one of those institutions were purchasing its supplies separately and not jointly. The handling and cartage cost thereby is not reduced to the jobbing house because they have secured a quantity contract. Each jobbing house consulted has emphasized this point.

The third variable to consider is the item of freight or express. The stewards of some of the institutions I visited were under the impression that the cost of freight was somewhat reduced when several institutions purchased jointly, since it enabled a jobber to start out a car and distribute a carload of supplies at the various institutions located along the same railroad. This impression, however, is not well founded in fact. According to Rule 5-B of the Official Classification Committee and approved of by the Interstate Commerce Commission, carload rates can be secured by the jobber only when a carload is "delivered at one forwarding station in one working day, by one consignor consigned to one consignee and destination." Under this ruling carload rates cannot be secured unless a whole



carload is delivered at one place and at one time. Any institution that can buy any supply in carload quantities can secure carload rates on freight; but this would be equally true whether the institution purchased separately or jointly. So it is evident that nothing is gained in the way of freight by joint purchasing of supplies.

As a general conclusion, I believe it can be safely stated that one institution of reasonable size can secure its supplies as cheaply as they can be secured by a joint contract entered into on behalf of a number of institutions.

In purchasing supplies, however, other facts than the price paid must be taken into consideration. These questions must be asked: Are the officers at each institution abundantly competent to pass upon the relative grades of samples submitted to them? Are the receiving officers thoroughly competent to pass upon the deliveries of supplies as compared with the samples previously submitted or as compared with the terms of the contract under which the supplies were purchased? If defective deliveries have been made, are such deficiencies of such moment as to warrant any separate institution bringing action against the contractor in order to force him to live up to his contract or to make restitution? These and other questions arise which give ground to an inquiry whether there may not be some advantages in joint purchasing, even though such joint action does not secure materially lower prices. I am of the opinion that joint purchasing is advantageous when done by the proper officers. My reasons are as follows: It is practically impossible for the superintendent or steward of any institution to be an expert in judging all lines of supplies used by the institution. It must be remembered that he must pass upon a great variety of goods, which in the commercial trade, are passed upon by a number of different experts. Among jobbing houses there is a separate expert for each of the following articles, butter, beef, eggs, tea, coffee, cereals, flour, dried fruits, cotton goods, woolen goods,

leather, hardware, etc., etc. Ordinarily each of these experts is a highly paid employee. The superintendent or steward of an institution purchasing its own supplies must exercise judgment in these various lines, and it is evident that their judgment cannot be good along all these lines, and such judgment must be expressed not only in passing upon the relative quality of samples submitted and in making out specifications for contracts, but also must be passed at the time of the deliveries of supplies to see that they correspond with the original samples. If purchasing is done jointly, however, a joint purchasing committee is warranted in employing some experts to pass upon qualities of these various lines of supplies. In this way expert judgment can be secured at a relatively small cost to each institution and considerable money will be saved. To illustrate the cost to the institutions of the lack of expert judgment, I will recall to your minds (assuming that you are familiar with the facts cited in my report) wherein it was shown that over ninety per cent. of the butter delivered to the New York State institutions was below the grade specified in the contracts. Likewise a large proportion of the beef did not meet the specifications, some of it being of extreme low grade. It may be safely stated that nearly all of the receiving officers at the various institutions are honest, but through inability or otherwise, they had failed to pass a judgment that would have excluded these inferior goods. A system of joint purchasing can overcome these difficulties, and though in New York State, previous to the investigation too little attention had been given to the matter, since the investigation referred to, the state law has been changed to enable the central departments to employ experts who will be at the disposal of the purchasing committees. Such experts have already been employed.

Not the least advantage gained by joint purchasing is the standardizing of supplies. It is desirable to compare the per capita costs in the various institutions along various

lines. For instance, the per capita cost of fuel and light, of clothing, of bed linen, of cleaning material and utensils, of various classes of foods, etc., etc. It is impossible to make such comparisons unless the qualities of goods used is known, and it is practically impossible to know these qualities unless they are uniform throughout the institutions that are to be compared. Where goods are purchased jointly this uniformity is secured and the statistics of the institutions thus supplied become comparable. It is of little value to compare food costs in two institutions where, for instance, one institution uses whole rice, costing \$0.06 a pound, while the other institution uses broken rice costing, perhaps, \$0.025 a pound—each furnishing an equal amount of nutriment, but their cost being materially different. Or, take another illustration. One institution may use prunes, size 60-70, at a cost of \$0.065 a pound, and another institution may use size 80-90, at \$0.05 a pound; the nutritive value is about the same in both cases, but the cost materially differs. This comparison could be carried through the various lines of food and through the different kinds of clothing. In order to make a comparison of any value in operating or maintenance costs of institutions, these institutions must, in some way, be put upon a basis where the qualities of supplies used can be known, and I do not believe this knowledge can be secured except those institutions use, in the main, the same qualities of supplies.

In considering state institutions, joint purchasing accomplishes another thing which is of no small moment, viz., that each superintendent knows that he is securing the same kind and quality of supplies as are all the other institutions in the state. No favoritism is shown. This is not the case where institutions are purchasing their supplies separately, which fact will be readily recognized without illustration. Joint purchasing tends to maintain a better temper of mind among superintendents of state institutions. There are other advantages in joint purchasing which need not now be cited.

but these three which have been noted are of sufficient importance, I believe, to warrant instituting joint purchasing in any state, or, I believe, among the private institutions, if they could devise some system whereby they could join together for the purpose of such purchasing.

Personally, however, I do not believe that such joint purchasing can be wisely done by any central officers not directly connected with the institutions. I do not believe that a Board of Control, or any other central department, or offices, or agent, can wisely or advantageously purchase the supplies for the institutions. I believe, all things considered, that they will be satisfactorily purchased only when purchased by a committee composed of officers of the institution who are to consume these supplies. These officers know their needs as they cannot be known by a central state department.

CHAIRMAN: It was thought by the President that the third paper would be ready, but he received word from Mr. Forbes that he would be a little late, and for that reason it might be well to open this first question of the general purchasing body for discussion at this time. I believe Dr. Bruce Smith is to open that discussion and, if he is present, we would like to hear from him

DR. R. W. BRUCE SMITH (Toronto): Mr. Chairman, Ladies and Gentlemen,—In considering the question of purchasing for an institution's use, we must always remember that there is a great difference between cheapness and economy. In Ontario we started a few years ago a scheme for purchasing from one central body of all supplies to be used by the Provincial, or, as it would be known on the other side, the State institutions. We found, after a slight experience, that purchasing by a central body was not in itself economical. We have therefore come to this conclusion, that it is very much better not to shift the responsibility for the purchasing of supplies from the institution that is to be supplied. That is, we found that in the aggregate the expense was greater than for an institution itself to have its executive officer made and held responsible for the purchasing of its supplies.

Experience in a Province like ours may be different from the experience in a large centre like New York City, but our experience, I think, in Ontario, is similar to that in the State of Indiana. In Iowa, as I understand, a system has been in vogue for some time through the State Board of Charities of standardizing and purchasing supplies, but not in the manner which has been outlined here to-day, rather having each institution responsible for the cost and the purchase of supplies, but at the same time accounting to the Central Department. This is exactly the system that we have in Ontario, and it works well. For instance, in our General Hospital system throughout the Province every General Hospital purchases its own supplies, but accounts to the Central Department of the Government, which exercises supervision and keeps an account of all supplies purchased at all the institutions. In this way, every institution has its record published from year to year in a state or a provincial government report. In that way the expenditure of every item for hospital maintenance is kept before those who are interested, and every one may see what it costs for every article used in every general hospital. I said before, centralization is not in itself economical in our experience. We think that it is better to have strict enforcement of the responsibility upon each superintendent, each superintendent realizing that his responsibility is not shifted from his shoulders to that of the central body. In that way we realize that we get the best results. I think that the per capita cost of the institutions in Canada compares most favorably with that of any other institutions in the world. The President, in his address yesterday, spoke of the desirability of having a cost system of accounting. I think that is very important. We have the cost system of accounting in vogue in Ontario, and would not depart from it. We are able in a moment to turn to any department of every institution in the Province and know what the per capita cost for every item of expenditure is in every institution in the Province. I think that the system of cost accounting can be carried out in every State and in every large city where there are many institutions, without having the necessity of going to the expense of having a central body do all the purchasing and have the responsibility removed from the head of the institution, where we think it more fittingly belongs.

CHAIRMAN: It has been thought that the purchasing and standardization of supplies are so closely identified that it would be well to have the papers read together. The discussion has been started, but as Mr. Forbes is here now, he will read his paper.



STANDARDIZATION AND PURCHASE AGREEMENTS THROUGH A CENTRAL HOSPITAL BUREAU.

BY W. J. FORBES, ESQ.

*Purchasing Agent of the Hospital Bureau of Standards and Supplies.*

Co-operative associations, conducted by firms and individuals having like interests, exchanging information and experience and combining mutual advantages, have proved factors for efficiency in business, and advanced commercial practice has suggested an analagous development for charities. The treasurer of a hospital, who is also a railroad official, submitted a plan for a central bureau for purchase agreements, based on that successfully operated under his direction for a system of railways, as a method of securing like advantages to hospitals.

An examination of the benefits likely to be derived from establishing uniform standards and purchasing in accord with definite specifications led to the establishment by progressive New York hospitals of the Hospital Bureau of Standards and Supplies, and as the Bureau was the first to be established with this aim, it is proposed to outline its history, methods and the results obtained. Standardization of hospital supplies and purchase agreements through a central hospital bureau established by voluntary association are here considered in relation to private hospitals, without reference to those under State or public control and in contrast-distinction to a system of centralization.

The Hospital Bureau is a concrete expression of the "get-together" principle. It was formed and is run and paid for by the hospitals, through their superintendents, and carries the best business practice into charitable work. The problem was to establish a proper central bureau, so planned and adjusted as to utilize the knowledge and ability of the superintendents in securing economy in place of cheapness, putting at the disposal of the institutions supplies se-



lected for best value, as shown by experience supplemented by expert mercantile advice, and saving the time of the superintendents from the unnecessary details of purchase, so that the broader administrative problems could receive greater attention. Central control was impossible. Therefore the association is voluntary and is conducted by an executive committee of the superintendents of the hospitals, planning for the greater good of the greater number, through increased efficiency, by means of recommendations to their fellow-members, thus avoiding the natural unwillingness of institutions to submit to central control.

Standardization,—in other words the selection of supplies of grades and qualities obtainable in the market which are best fitted for economical hospital use (not necessarily the cheapest in price),—is the primary purpose of the Bureau.

The Bureau seeks to determine what supplies are best adapted for hospitals, by gathering all possible information, samples, etc., and submitting the results to the judgment of the executive committee, consisting of a number of hospital superintendents specially qualified by knowledge and experience to make a selection. This involves the joint experience of all the members, and is the action of the superintendents, since no outsider can fully understand hospital requirements and uses. In the progress of this investigation it is sometimes found that local conditions and local markets should govern, or that only a portion of the hospital requirements are capable of standardization. It is frequently necessary to provide a range of different qualities, to suit the varying requirements of several institutions; and in other instances, where agreement on qualities or source of supply is not readily reached, no attempt is made to standardize; but experience has shown that a large proportion of the principal hospital supplies are readily susceptible of standardization.

A selection having been made, the next step is the preparation of specifications, which embody a full description

of the article so selected, bearing in mind not only what is desirable, but what is obtainable in the market. In drawing up specifications, the reports of the Departments of Agriculture of the United States and of State institutions are consulted, and the help given by the best merchants has proved invaluable. Sometimes a manufacturer's specification is adopted for an article proven satisfactory by experience, thus removing the risks which exist under a generic specification. In other instances, the Bureau has had the benefit of kindly assistance from professional and non-commercial experts. In one such case the specifications resulted in an alteration in the method of manufacturing and in improvement of the quality of a chemical largely used by all hospitals, a result from which all can now benefit. The details of the specifications provide a means for settling uncertainties as to whether the articles delivered are inferior or whether unskilled use or unwise selection is the cause of dissatisfaction.

The specifications having been approved by the committee are embodied in the form of an agreement between the Bureau (on behalf of its members) and the suppliers, which agreement is, in effect, an option enabling any member to purchase from the supplier any of the standardized articles at the agreed terms, at such times and in such quantities as the purchasing hospital may desire; but as only one agreement is made for each particular article recommended by the Bureau, it carries the moral assurance that the members of the Bureau will purchase from the supplier designated, since the agreement is made by the superintendents of the largest buyers.

The usual form of agreement is an accepted proposition from the selected supplier for such of the described articles as the members may desire to purchase, in accord with full specifications, frequently accompanied by samples, and at acquainted prices and conditions. The term of the agreement is continuous, subject to termination on stated notice,

but with a **fixed minimum** duration. There is usually a guarantee of lower prices in case lower prices are given to any other customer during the continuance of the agreement. Copies of agreements and specifications are distributed to the members, with the recommendation of the executive committee.

In closing agreements for standardized articles, different qualities, as well as different descriptions of articles, for varying uses, are provided. For instance, in coffees and teas, qualities are standardized suited either for **help or private use**, with a **range of selection** for each use. In absorbent gauze, the specification provides for different meshes, giving not only the count but the weight per yard; all gauze standardized, however, is of the heavy construction, since it has been found more advantageous to pay a higher price for the heavy weight, particularly since the washing or recovery of gauze has been generally practiced.

Special needs are cared for by a provision wherein the supplier agrees to furnish other qualities and varieties at his best market prices. A clause is frequently embodied in the agreements, guaranteeing that any reduction in the market price shall be accorded to the hospitals, although any advance in price is not operative until a specified time has elapsed. Suppliers are disposed to consider these conditions in the case of hospitals, as they would not in the case of commercial bodies, inasmuch as profit is not the object of purchase and the consumption is unaffected by market changes.

Provision is made for a fluctuating market by establishing prices for a short period, with revision close to market conditions at fixed intervals. For example, prices on poultry are revised monthly, and on meats twice a month, on the basis of standard specifications. Where the harvest-time governs the season of favorable purchase of natural products, such as canned goods and dried fruits, agreements of short duration give an opportunity to cover re-

quirements for deliveries throughout the year. Changes in price and details are brought to date by supplements to the agreements. All orders are given directly by the hospitals to the suppliers under the agreements, and the hospitals receive invoices direct, each institution being liable only for its own purchase, which it pays for directly to the suppliers. As the suppliers agree to carry a stock of the standardized goods, time is saved in filling requisitions, and the hospital is relieved from the expense of keeping stock in reserve. Each hospital has, in the detailed specifications, a check on the quality of the goods received. Tests and analyses of samples taken from actual deliveries are also on occasion made by the Bureau.

The Bureau has now in effect fifty different agreements, covering many articles of hospital supplies, of which the following is a partial list: Alcohol, blankets, chemicals and drugs (six agreements, including a wide variety), clinical thermometers, coal, cocoa, coffee, crackers, ether for anæsthesia, gauze, green soap, hypodermic syringes, incandescent lamps, linens for table use, meats, olive oil, paints, etc.; poultry, preserves, rubber gloves, cots, tubes, catheters, sheets and pillow cases, surgical instrument repairs, soaps, tea, toilet paper, towels, vinegar, washing soda, whiskey, and Z. O. plaster. Canned goods and dried fruits, to be delivered through a year, were covered in the favorable season by agreements, on which the time for exercising the option has expired.

From this list the varied nature of the work will be seen, and the wide range of the supplies which have already been standardized.

Eighteen months' experience in operating the Bureau has demonstrated its actual benefits. In addition to a considerable saving in the cost of supplies, the agreements negotiated by the Hospital Bureau contain valuable information, drawn from the experience of the members or obtained from the various manufacturers from whom bids

were requested. This information aids greatly in introducing the most economical article or method best suited to hospital needs, helps to overcome possible prejudices of members of the staff, who might hesitate to urge individual preferences against standards adopted after careful investigation and consideration by a bureau of associated hospitals, and prevents much unthinking or unfavorable criticism of the quality, price or method of purchase of supplies, by those insufficiently posted or unfriendly to the administration. The standards recommended by the Bureau, describing exactly the qualities and articles which appear best suited for hospital purposes, offer the most trustworthy suggestions and advice which can be obtained, and the educational value of the Bureau should therefore be given consideration as well as the economies secured thereby.

The advantages accruing from investigation, after careful comparison of expensive analyses undertaken at the instigation of the Bureau, are secured for the joint membership in the case of certain articles, though the time for individual investigation would not be warranted where the purchases for a single institution are small. As an illustration of combination for special hospital needs, the Bureau has secured a 3-minute clinical thermometer, made in accord with specification, equally exact with those taking a shorter time to reach a maximum, but more durable, decreasing breakage by fifty per cent. as well as costing materially less in the first instance. Where quantity schedules are in force, the benefits of the combined amounts purchased are self-apparent. One of our members, by purchasing incandescent lamps direct under the agreement, saved over \$150, as compared with the price that would otherwise have been paid in purchasing from the electric fixture makers as part of a contract.

It was found that certain articles had been sold to the different members directly or indirectly by the same firm



at different prices; through the Bureau a price was secured for each member lower than any of them had previously paid.

Again, the Bureau acting as distributor has been able to close agreements where the sellers were accustomed to confine their outlet to the trade and were unwilling to supply the individual members on wholesale terms. In the long run, each member gains by most of the agreements, if not by all, since if A finds a better source of supply, it becomes available for B, C, and D, and conversely for each member. Sometimes no better results can be secured by collective than by individual purchasing, and the matter is left to individual judgment.

The work of the Bureau has been found helpful, both in raising the quality where an uneconomical grade was being purchased, and by lessening a tendency to buy supplies of higher cost than was needful. A prompt corrective for unsatisfactory deliveries has been found in the specifications and in the fact that the agreements are not obligatory and may be annulled by the Executive Committee if dissatisfaction exists or if more advantageous arrangements can be made elsewhere.

While the agreements jointly entered into by a committee of superintendents do not bind the members, loyal cooperation in adhering to the standard warrants the assurance given the suppliers that an agreement carries with it most of the purchases of the members; thus the Bureau preserves the benefits of individual initiative, leaves intact individual autonomy, and yet secures the advantages of cooperation by placing at the disposal of the members specifications, with prices of supplies, and recommendations for use based on a full knowledge of hospital requirements, and further leaves each institution free to secure the advantages of local markets and local conditions.

The Hospital Bureau established by New York institutions has been the subject of inquiries in this country from



San Francisco to Maine, as well as from England. It has therefore been felt that its benefits should not be confined to New York institutions, and provision has been made for non-resident members who desire to share in its advantages, and whose co-operation, in increasing the volume of purchases, will add to the ability of the Bureau to benefit all.

Membership dues for maintenance of the Bureau have cost non-resident members \$10 a month and resident members \$20 a month for each \$50,000 (or fraction thereof) of such members' annual current expenses, with maximum monthly dues of \$50 and \$100 respectively for non-resident and resident hospitals of the largest class.

*Note.*—Copies of Reports, Organization Agreement, and printed details are at the service of all who desire further information, and the members of the American Hospital Association are invited to call at the offices of the Bureau, 381 Fourth Avenue, New York.

CHAIRMAN: The matter is now open for discussion, and I should like to ask if Rev. Dr. Kavanagh will say something on this subject.

#### DISCUSSION

REV. A. S. KAVANAGH (Methodist Episcopal Hospital, Brooklyn): I will say, seeing you have called me up, that we have received some of the benefits of the bureau during the past year. We have not reaped quite so much benefit as the speakers indicate that some of them have, but I do not rise to speak against the Bureau. I think it is still on trial, and if, during the year or two that it has been in existence, we have reached the conclusion that something is really being accomplished, even though not so much as some of us had hoped, I do not advise that it should be discontinued until it has been thoroughly tried out. Before we get through with this experience, we may all find that we have a fine institution, but I have not been impressed particularly. The best thing it has done for us is to prove to us that we have been buying pretty well before.

CHAIRMAN: I wonder if Dr. Thomas Howell will speak of his experience on this subject?

DR. THOMAS HOWELL (New York Hospital, N.Y.): The New York Hospital, of which I am Superintendent, has been a member of the Purchasing Bureau since it started, and we feel that the Purchasing Bureau has been a good thing for us. Frankly, I would say that we thought we were pretty mean buyers down there, that we were getting prices about as close as dealers would give them. I think one of the important features of the Bureau is the bringing about of standards for hospital supplies. We felt at the New York Hospital last year that we saved money buying through the agency, and I know that if the agency had a larger membership, so that we could increase our purchasing power and could reduce our individual expenses to the Bureau, that the agency would be a great success.

CHAIRMAN: In all discussions of this kind, it is not a question as to a person being in favor or against it, but we are all here wanting to learn something. Now we have heard from the New York Hospital, I wonder if Dr. Fisher, of the Presbyterian, will not tell us something of his experience?

DR. C. I. FISHER (New York): The Presbyterian Hospital has believed that it has been benefitted by its relation to the Bureau. One special sense of relief which has come to me as Superintendent is the fact that when contracts have been made by the Bureau, I have felt that that matter had been threshed out, we have not got to go to the sellers to look over goods and discuss and take a lot of time in deciding whether we will have this, that, or the other. I feel that the Executive Committee of the Bureau which meets every two weeks, has, I believe, without failure since they began discussed the various subjects and standardized those things which could possibly be standardized, and we feel that when the contracts are signed, it is as I say, that matter has been threshed out, and that we may order our goods according to those contracts, feeling that we are getting a satisfactory quality of goods, adapted to our needs and at prices on which there can be no question, and in that sense it has been a great relief to the Superintendent and those who have to do with the selecting and purchasing of supplies.

DR. FREDERICK BRUSH (Post Graduate Hospital, N.Y.): I think the Post Graduate Hospital may report that the Bureau has given it some value, not so great a pecuniary gain as we had expected, but surely it has been of value in the way of releasing one rather high salaried official or clerk to other necessary duties. It helps to counteract unnecessary criticism of standards and quality, giving us the power, with the Bureau of Standardization back of us, to get along much more quickly and smoothly; with much of the installa-

tion of equipment in our new extension plant, we have availed ourselves of the Bureau very acceptably for many of these articles we had hoped to be standardized had not come into that list. It has worked out that the meetings of the Executive Committee may be said to have been highly educational, they have at least been so to me, probably more so than to many of the older members. No meeting but what has shown some Superintendent present probably that his institution was laggard in some particular, and I have always noticed a great deal of note-taking at the meeting. We have come closer together and have learned a great deal through the very operation of the Bureau. We report not a great deal, though some financial saving, but much gained in machinery and management of our institutions.

MR. REUBEN O'BRIEN: It gives me some pleasure to come forward this afternoon and express my experience of the Bureau of Purchase. Some eighteen months ago when we organized I was very skeptical as to any advantage to be gained by getting together, but as time has gone on, comparing my prices with those that I had years back, I have been brought to feel that there is a decided gain financially for our institution. While it is hard to estimate just what it means for one year's work, as prices change from year to year, I have tried to make some estimate as to the financial saving, and feel that there is a decided saving for our institution, and as Dr. Brush has expressed himself, the saving that it means to one in the position where his time is required for other work, is more than words can express, especially if you are in an institution where you do not have plenty of assistants. You have your time free for the greater work of the institution. It certainly is something that is most important. I feel that there is a great work for this institution, we are just beginning to see what can be done in the matter of standardizing.

CHAIRMAN: I should like to ask Miss Cadmus of the Manhattan Maternity to tell us her experience.

MISS NANCY CADMUS (New York): I am still somewhat on the fence in this matter, for the reason that our hospital is very small; our supplies are of course never gotten in any great abundance, but I think I can say that we have had benefits from it more of the passive order than of the active. We are now within a month of the closing of our annual work, wherein I shall be able to find for myself and for my board the actual benefits or disadvantages, if there are any, that we may have received by being a member of this Bureau. I certainly would be very sorry to see it abandoned. I believe it is quite worth trying out a second year, and I shall so recommend to my Board.

MISS N. McCALMONT: I should like to know if any hospital has withdrawn from the Bureau, and if so, what their reasons are.

CHAIRMAN: I will ask Mr. Forbes to reply to that.

MR. FORBES: There are three institutions who have withdrawn, and as one of them was the Methodist Episcopal Hospital, I think probably Dr. Kavanagh can voice his reasons, or has already done so.

CHAIRMAN: What were the others?

MR. FORBES: Mount Sinai, who have joined the Hebrew Institutions Purchasing Company, and the French Benevolent Association.

DR. ROSS (Buffalo): I can see how the Purchasing Bureau can possibly work for New York, for the conditions under which the institutions here are working are very similar, but I can hardly see how it can be made profitable for the institutions more remotely situated. For instance, I am at the other end of this State, located in an agricultural district, a great many of our supplies I can buy much cheaper there than I could through the Bureau. I am located on good railroad lines where I can buy our supply of coal at a much cheaper figure than you can here. We can buy our milk at a very much lower figure than you can here. But I do not suppose we can, because that is standard as much as gold is standard, but I cannot appreciate how it is going to benefit institutions outside of New York as much as it does those here.

CHAIRMAN: The suggestion has been that on the question of standardization of the furnishings of hospitals, linens, sheets, towels, that it would be of great benefit. It was first thought by superintendents that there must be six or eight different kinds of towels, but I think it was found that there were twenty to thirty different kinds in our private wards. That has been referred to as well as the benefits of threshing out these things and looking after them. In purchasing those materials it would not make very much difference if they are shipped direct from the cotton mills in Massachusetts, it comes direct and will appear to the advantage or disadvantage of each one.

DR. H. B. HOWARD (Boston): I would ask if Dr. Ross, for instance, would not get satisfaction from such association just from the mere checking up of what the other institutions are doing and what he is doing. I suppose this Central Bureau keeps forwarding around to all the members just what it can do in each line. I was wondering whether a comparison of methods would not aid to place your orders intelligently rather than carelessly or haphazard or with uncertainty as to whether you have done well or ill. It

seems to me that this New York experiment is of great advantage, now that it has been started, to have it tried out to the end, it would be a great advantage to the rest of us to see what can actually be done in that direction. I shall hope that it will get sufficient support so that the experiment there can be carried out with earnest effort so that it should not be given up until it was absolutely plain to the citizens of New York that it could not be a success. It seems to me that it is worth a great deal to have it carried much farther than it has been, and it has occurred to me whether or not for me personally, not running the institution, but soon to be called upon to equip one, whether it would not be a good thing for me, even in another city, just to check up to see whether I was equipping intelligently or not.

DR. W. L. BABCOCK (Detroit): As Dr. Howard has suggested, it strikes me that this experiment here in New York has shown the way to many of us who live in smaller cities. As I suggested in my address, we can do a great deal toward comparing notes with our brother superintendents. I have found it of advantage to consult the neighboring superintendents in Detroit as to the prices of goods that we are buying. We have had one or two striking examples of the benefits derived from frequent consultation on prices. To illustrate, their hospital called us up at one time and asked us what price we had paid for turkeys for Christmas. This was just before Christmas. We replied we paid 15 cents—this was several years ago. They asked us whom we bought them from and we named the market company, and they stated at once that they had just got a quotation from the same market company for 100 pounds more at 16 cents, and we had already had our turkeys delivered at 15 cents, the same grade. It is unnecessary to say that that market company has not sold that hospital any turkeys since. By that kind of checking up we can keep track of the local dealers and not permit them to charge the hospitals of the city two or three different prices. It has come to my notice that even wholesale jobbers are charging two or three different prices, and we have been able to stop that to a considerable extent, especially in canned goods.

DR. FISHER: I cannot forbear telling a story, although the joke was on myself. One day we were looking up the question of X-Ray plates. Mr. Forbes called up some of the members of the Bureau to know what they were paying and where they got their plates, and I told them where we were getting our X-Ray plates and the

price we were paying, but I said, "I cannot allow you to quote the price, because it is a specially low price to us." He said, "Don't you worry, that same man is selling goods to other people cheaper than he is to you."

CAPTAIN TOWNLEY: As a member of this Purchasing Agency, and a very enthusiastic one in the beginning, I should like to say a word for the hospital that I represent. We went into this thing because we thought we were going to save money, and on two articles alone that the Bureau has made contracts for, we more than paid our assessment. The weakness of this Bureau is this, in a nutshell, that the supplier will furnish some person who is not a member of the Association at the same price or at a lower price. If we could bind the party contracting with the Bureau to sell no other institution at a lower rate than he sells the members, there would be no end to the success, it would be not only an experiment, but a success. But it is because the supplier himself is not honest and will sell to me, if not a member, cheaper than he will to John Smith, who is a member.

DR. ROSS: That does not indicate dishonesty in the seller.

CAPTAIN TOWNLEY: I think it does.

CHAIRMAN: May I say a word of thanks to the Association for the honor they conferred upon me, and I will not retire to let your President take the gavel for the business work of the Association.

(President Babcock in the chair.)

DR. WINFRED SMITH: I think this Association is indebted to Mr. Van Duzer for his willingness to come here this afternoon and preside at our meeting, and I move a vote of thanks on the part of the Association to Mr. Van Duzer for presiding at our meeting this afternoon.

Motion carried by a rising vote.

Adjourned to meet at 10 o'clock a.m., next day.



## THURSDAY, SEPTEMBER 21—MORNING SESSION.

PRESIDENT: We have a short business session this morning, and after the reports of the three committees which you will see on the programme, we will take up the matter of new business, and any one who has any resolutions to introduce will have an opportunity to do so.

DR. E. B. SMITH: I should like to make a motion. We have in this country a lady very dear to all of us that has been sick for a number of weeks, Miss Clara Barton. I wish to make a motion that we send our greetings, with best wishes, to Clara Barton.

Motion seconded and carried.

TREASURER'S REPORT FOR THE YEAR ENDING  
SEPTEMBER 16th, 1911.*Receipts.*

Membership fees and dues .....	\$2,545.65
Annual reports .....	5.00
Cash balance, September 22, 1910 .....	1,206.92
	<hr/>
	\$3,757.57

*Disbursements.*

Printing .....	\$831.61
Clerical and stenographic work .....	565.00
Postage . . . . .	299.59
Express . . . . .	20.00
St. Louis Convention .....	12.00
Exchange in checks .....	9.45
Sundries . . . . .	24.75
Cash balance, Sept. 16th, 1911 .....	1,995.14
	<hr/>
	\$3,757.57

Motion that the Treasurer's report be adopted carried.

PRESIDENT: The Auditing Committee inform me that they are not ready to report. Is there any new business to be brought before the convention?

DR. CLOVER: I beg to offer the following resolution:—

Resolved, That a committee of five be appointed by the President with power to represent the Association in memorializing Congress to place hospital instruments, implements and commodities on the free list and also the power to expend such sum, not to exceed \$500, as may be necessary to accomplish this purpose.

I doubt if any expenditure of money beyond that necessary for postage stamps, etc., be necessary, but it has occurred to me that if you see fit to appoint this committee that they may need the aid of counsel, and it also may be necessary or advisable to do something in the way of publicity work. I move to adopt this resolution.

DR. KAVANAGH: I am glad to second the motion for the adoption of this resolution.

DR. FISHER: It does seem to me that we ought to offer that proposition with a great deal of courage, that is, those of us who have to do with hospitals where there are training schools and where there is considerable contingent of a house staff. I do not see why we should not be regarded as educational institutions. It is true that we started as charitable institutions, but the educational side of our work has grown and is constantly increasing. It seems to me that this is a very fair proposition. We at the Presbyterian and some other hospitals have tried from time to time to get instruments in free and thus far we have failed to do so. I think when the tariff was revised the last time that there was a little softer feeling in the hearts of the Congressmen towards us than there was before, and I think this is going to be an opportune time to present the matter again.

DR. HURD: I would suggest a modification of the resolution in this way; that we request the same tariff privileges as other educational institutions; if Dr. Clover can see his way clear to make it read that way, I think it will make it stronger before Congress, we ask it on account of our educational work.

DR. CLOVER: I make the change with pleasure.

DR. BRUCE SMITH: In Canada we enjoy that privilege now. It works well, and I hope you will secure it on this side of the border.

MR. PARKE: I find on inquiring from the Government that our Government has put in the words, "Solely for educational purposes." We are in the same position, with the exception of surgical instruments, that the American people are. Will you explain the term "solely"?

DR. BRUCE SMITH: In the Province of Ontario we put a more liberal interpretation on the customs clause.

PRESIDENT: Is there any further discussion? If not, I will ask Dr. Brown to read the resolution again.

Resolution, as amended by Dr. Hurd, was read and adopted.

DR. WASHBURN: All of us who have had occasion to compare reports of one hospital with another and see what our neighbors are doing in medical and surgical work have appreciated the difficulty because of the lack of a standard nomenclature. For this reason I would introduce this resolution:

Resolved, That it is expedient that a standard nomenclature be adopted by the hospitals represented in the American Hospital Association: that a committee be appointed by the President to formulate such a nomenclature, two of whom shall be members of the Association, and, further, that such committee be empowered to expend a sum not exceeding \$500 in carrying out the proposed work.

PRESIDENT: You have heard this resolution, what is your pleasure? This is an important subject, I should like to hear some discussion.

DR. KAVANAGH: Some of our most eminent medical men have given a great deal of thought to this question, and the Bellevue Hospital has furnished you the data that you are looking for now and prepared by very competent men; whether there are more competent men than those who prepared the Bellevue booklet, I am not prepared to say, but it seems to me so much work has been done on this line and done by thoroughly competent parties, that the expenditure of any special amount of money out of our treasury is hardly necessary. I do not want to oppose the motion, I question whether we will be able to have an abler committee than has already done some of this work.

PRESIDENT: Dr. Smith, have you anything to say on this subject?

DR. WINFORD SMITH: I have only this to say, that the Committee on Clinical Records of Bellevue and Allied Hospitals, four members of that committee have been working for several years on nomenclature. They published several years ago a book on Bellevue nomenclature that has been revised within the last year, and a small book has just come from the press which represents the work of that committee. It has proven very satisfactory in the hospitals of the city, that department known as Bellevue and Allied Hospitals. It has also been adopted, I think, by several other hospitals of New York City, and I might add further that the com-

mittee in working up this subject have been in constant touch and communication with the Statistical Bureau at Washington and with the committee of the American Medical Association. It has been their endeavor to make it a standard work. I personally feel that a committee of this Association would be a very desirable committee to consider this, it would represent then the Association representing the hospitals, and certainly the hospitals represented by this Association should give some detailed study to the subject, inasmuch as those statistics making use of such a nomenclature are published in our Annual Report, and it would seem to me to be very desirable. The fact that this book is already out might reduce the labors of such a committee to a minimum. If so, so much the better; but it would seem to me that such a committee would be desirable, possibly taking this book as a standard from which to work. If Dr. Coleman is present, as a member of that committee I think he could explain that.

DR. COLEMAN: It is more or less difficult, being a member of that committee, to say anything without apparent bias. We have worked over this nomenclature for ten years, during the last four of which we have been in constant communication with Dr. Wilbur, of the Bureau of the Census. The present edition of the book, which has just been issued, has been used by Dr. Wilbur, particularly with respect to the assignment of our terms to the "International Classification," which, as you perhaps know, had its origin in Chicago, not in Paris, as ordinarily supposed. Dr. Batio's name is connected with it more often than any one's else, and he, perhaps, deserves more credit. This classification is in use now by about thirty different nations, including ourselves. It would be obvious to you that unless there is co-operation among our different States and among the different nations, that it is impossible to get statistics that are comparable. A man on the Pacific Coast will use a term for a disease that we know by another name in the East. Any nomenclature which is constructed should be constructed in such a way that the terms are readily translatable into the terms of the International Classification. Our vital statistics in this country are ranked by foreign nations almost on a par with those of Central Africa. Only one-half of the population in the United States is included within the registration area of the Census Bureau. That means that we have no statistics from approximately one-half of the country, and the statistics that we get from the other half are vitiated by the fact that it is impossible to compare them. I might tell you of one or two diagnoses that have reached the

Census Bureau, to illustrate my point. Dr. Wilbur will publish in his forthcoming Manual such diagnoses as "Visitation of God," and he also has received death certificates in surgical cases where the name of the surgeon has been signed upon the line assigned for the cause of death. The nomenclature question is an extremely important one, and one that I think the entire medical profession of the country, including this Association, would do well to devote a great deal of attention to.

DR. KAVANAGH: It seems to me that this discussion makes very clear what I was trying to get at in an off-hand way; that is, that this work is being done thoroughly at this moment by the most competent men that could be selected to do the work. If the motion should be made that a committee be appointed to consider the Bellevue nomenclature to see whether we would adopt it or not, that would be a good motion, it would be a harmless motion, because they would come back reporting there was nothing better in sight, and they could not improve upon what has already been done. Why should we make an appropriation of \$500 for this special business when it is done already?

DR. WASHBURN: To my mind the remarks of the Doctor prove just the reverse of what they prove to the mind of Dr. Kavanagh. This committee which has drawn up this nomenclature represents Bellevue Hospital. As I understand it, other hospitals have had other committees working on the same subject. The hospital which I have the honor to represent had such a committee several years ago, and we adopted a nomenclature which we think is pretty good. That is just an example that standardization is necessary. I understand a committee of the American Medical Association is working on this subject. That will give the committee which we appoint an opportunity to find out what has been done, and if it finds that the Bellevue system is the best, why, to report that back; if it finds out that our system which we adopted is better than Bellevue, let it report to that effect, and it should certainly co-operate with any existing committees. It is very possible that it will not be necessary to spend much money, we should hope not, but I think it is very important that this Association should aid in the standardization of the nomenclature of medical and surgical diseases from the point of view of hospital administration.

PRESIDENT: I would say that I am not going to appoint any of these committees, as these resolutions authorize their appointment by the incoming President, therefore, what I say on this subject is without any personal bias. I believe that it is the duty of this

Association to adopt an authoritative nomenclature and classification. You will note that that resolution reads to expend not to exceed \$500. I do not think the incoming President is going to appoint a committee who are going to spend \$500 just for the sake of spending it, because they have the authority. As Dr. Washburn says, if the nomenclature of Bellevue Hospital is the nomenclature that we want, the committee will probably come to that point, or if it is the Massachusetts General Hospital nomenclature, it will probably come to that point, but I think we should declare ourselves at least not later than the next convention in favor of some nomenclature which will spread it throughout the country to a greater extent than the adoption of a nomenclature by any one hospital. The committee in all probability would find their greatest work in simplifying a classification that can be used in our report. This nomenclature of Bellevue Hospital is a very extensive one, I take it, from what I have seen of it, that has to be simplified to make it a practical nomenclature for publication in our reports.

DR. ANCKER: I have gone into this thing this morning as extensively as I possibly could during the time that I had, and I am with Dr. Kavanagh in his contention that we should not expend any money for any such purpose. I am satisfied this is a splendid classification. I am so satisfied with it that I have made overtures to the person on the committee here to come west at our expense to establish the same system in our institution. I shall oppose that resolution.

PRESIDENT: The question has been called for. Has the resolution been seconded?

Seconded by Dr. Howard. Motion put to vote and lost by a rising vote.

DR. KAVANAGH: I am sorry to have the thing entirely lost because it came in just the shape that it did. I felt that I had to take the position that I did in regard to it, and yet I think that a committee to take up the Massachusetts General nomenclature and the Bellevue and any other published nomenclature would be a good thing to report to us next year. That work has been done by able men, but the Massachusetts General may have been more able than Bellevue, or vice versa.

PRESIDENT: Dr. Kavanagh, will you prepare a revised motion?

DR. KAVANAGH: I would present the same motion that the Doctor has presented, omitting the appropriation. I think the motion is complete. (Seconded by Dr. Ancker.)



PRESIDENT: I will ask the Secretary to read the motion without the last clause.

The Secretary then read the motion as amended, and the same was adopted by a rising vote.

DR. ROSS: I have been asked to present the following:

Resolved, That it is the sense of this Association that a committee of three members be appointed by the President to investigate the subject of fire and liability insurance in hospitals and report to the Association at the next convention.

Be it Further Resolved, That a sum not to exceed \$500 be appropriated for the expense of this committee.

PRESIDENT: As the motion does not seem to be seconded, it will be dropped.

DR. FREELAND: In order to get it before the Association, I wish to offer this resolution by request. There is no appropriation in it:

Whereas, A great many manufacturers of hospital supplies have applied for the privilege of showing their products in some building adjacent to the Convention Hall, and are willing to pay the Association for the privilege of so doing;

Resolved, That the President be authorized to appoint a committee to consider this question and report before the close of this convention.

DR. HURD: We settled that some years ago, that the Hospital Association has nothing to do with personal exhibits, and I for one am prepared to take a very strong stand against it. This is not a commercial undertaking.

DR. KAVANAGH: I rise to second the motion. I do not purpose to take a very strong stand for or against it, but I wish to say this: that members of this Association that have come from a distance and do not live near Chicago, or Baltimore, or New York, find these exhibits a very great convenience. Those of us who live within a few miles of where we can have the exhibits with ease, they do not mean much to us. As I understand, these people are willing to pay the expense of their own exhibits, if we are at any expense they meet it. It seems to me we do not endorse anything that they exhibit, but if we allow a reputable house to put on exhibition their wares, it does not seem to me that we are injuring any one, and we are helping a very large proportion of the membership of this Association.

DR. WASHBURN: Any commercial house who desires to hire a hall in this neighborhood and make an exhibit has a perfect right to

do so as the matter stands, and they can distribute all the dodgers that they wish, but I should be very emphatically opposed to this Association receiving any money for such exhibit. I think such a motion is unnecessary.

DR. CLOVER: I was about to say substantially what Dr. Washburn has just said. It seems to me there is no reason why any consent should come from this Association for any commercial exhibit. They are perfectly at liberty to hire a building at any time they see fit and at any place.

MISS AIKENS: As I understand this resolution, it is not stating that the Association adopts the resolution, but that it simply appoints a committee to consider, and I very strongly urge that a committee be appointed to give it a little more consideration than is possible at this time.

DR. MORRILL: We have now an exhibit which is said to be non-commercial, it is only partly so. It is a recognized fact that we can only control things by recognizing them; why not have two exhibits—a truly non-commercial and a commercial, with the commercial paying its own expenses and consolidated in one place? We have now commercial exhibits in this building, spread all over the place. If it could be handled in a systematic manner by the Association without profit, but simply self-sustaining, I think it would be an advantage, both to the exhibitors and to the Superintendents.

DR. SMITH: I think that we should have the profit to go to the Association. All scientific bodies have committees appointed to pass on exhibits, and then they derive a revenue from it. Take the American Medical Association, all the State Medical Associations, they have their meetings in a large building where they will have ample opportunities for commercial firms to exhibit their wares. That does not say that they put their stamp of approval on it, but simply allow them to do it. People coming from the outside, away from large commercial centres, can see these exhibits and they can get almost as much out of seeing these things in the exhibit as they do from the meeting. I hope the motion will prevail.

PRESIDENT: Any further discussion? The Secretary will read the resolution again. This motion has been seconded. All in favor of the motion will please rise.

Motion carried. Ayes 52, nays 38.

MISS ANDERSON: I offer the following resolution:

Moved, That the incoming President be authorized to appoint a permanent Secretary to take charge of the Association non-commercial exhibit and to allow the sum of not exceeding \$250 a year to defray expenses.

DR. KAVANAGH: If there are two hundred and fifty persons in this room at this moment, I am sure that we should be very willing to pay \$1.00 a head rather than have that exhibit omitted from this programme. I think that exhibit will mean much to us throughout the entire year. I wonder how it could be gotten together without some appropriation, and so, while I shrink from appropriations, as much as any of the rest of you, I will second this motion, because I believe we cannot afford to do without that exhibit, and it must cost something in order to furnish it as it ought to be furnished from year to year. I second the motion.

DR. GOLDWATER: I want to call attention to the fact that the motion has been presented in a form that may mean difficulty in the future. If a permanent officer is appointed by some incoming President, without any provision in the constitution or by-laws of the Association, I do not know how it can be disposed of. I therefore make the suggestion that the person offering that resolution withdraw it and study its significance with reference to the by-laws of the Association.

PRESIDENT: I think if a permanent exhibition officer is to be appointed or arranged for, that it will be necessary to amend the constitution and by-laws, and I suggest to Miss Anderson that she present the matter in that resolution to the chairman of the Committee on Constitution and By-laws and arrange for the presentation of an amendment to the by-laws this afternoon. That will permit us to pass definitely on that subject to-morrow.

DR. BOYCE: I have been asked to introduce this resolution:

That in the opinion of the members of the American Hospital Association, there is absolutely no danger to the inmates of dwellings in the vicinity of contagious disease hospitals, providing there is no communication between them and the hospital patients.

DR. HOWARD: I should hope that the Association will not get into the habit of expressing opinions on that subject. I think it is true that we have pretty clear ideas about it, but I should be sorry to have the Association go on record as expressing its opinion by resolution or motion in regard to whether a contagious hospital is a menace to a community or not.

DR. DREW: I think it would be awkward in a year or two if we should change our minds on that subject.

On motion, the resolution was laid on the table.

## REPORT OF MEMBERSHIP COMMITTEE.

To the American Hospital Association:—

Your Membership Committee begs to report, as follows for the year 1910-11:—

Two hundred and five applications for membership were received during the year by the Secretary, and were presented to the Membership Committee for their approval.

Of these 184 are active members and 21 are associate members. Of the active members 33 are trustees of hospitals or members of hospital association boards, and 151 are superintendents of hospitals.

The new members belong to the following States and Provinces:—

Arkansas, 2; North Carolina, 1; California, 6; Connecticut, 5; Canada, 15; Colorado, 2; District of Columbia, 2; Delaware, 1; South Dakota, 1; North Dakota, 1; Georgia, 3; Indiana, 1; Iowa, 4; Illinois, 15; Kentucky, 2; Kansas, 1; Maryland, 2; Maine, 1; Massachusetts, 19; Michigan, 4; Montana, 2; Missouri, 9; Minnesota, 2; Mississippi, 1; New Hampshire, 2; New Jersey, 7; New Mexico, 1; Nevada, 1; North Carolina, 1; New York, 40; Nebraska, 1; Ohio, 15; Oklahoma, 2; Oregon, 2; Pennsylvania, 13; Philippine Islands, 1; Rhode Island, 1; Tennessee, 2; Texas, 2; Virginia, 4; Vermont, 3; Wisconsin, 3; Washington, 2.

## THE FUTURE OF THE TRAINED NURSE.

BY MISS NANCY P. ELLICOTT.

When I was asked some months ago to prepare a paper to be read at this meeting, my first feeling was one of reluctance at the thought of occupying your valuable time with the fruits of my none too numble brains. There is, however, a subject which lies so near my heart that I could not allow this opportunity to present it to escape me. It is of the nurses that I would speak—of the future, and what it may hold for each and every one of us.

There seems to be no end to the vista that stretches out before us, of activity, usefulness and advance for the trained hospital nurse. Undoubtedly during the next ten years she will enter fields that to-day are closed to her. One has but to look back over the last decade, to be convinced of this. We need not, therefore, be anxious lest there should be an overproduction of good nurses, for the future seems to hold ample opportunities for all of them. There is another side to the future, and it is this side, that I wish to call to your attention.

Three requisites are essential in the bright and useful future toward which our young graduates turn their eager faces. These requisites are health and youth and vigor. The trained hospital nurse has been so short a time in existence that there are few veterans in our ranks, and it is only now that we begin to appreciate the pressure of the question of what is going to become of us in our old age. We find, in some instances, that, either the alma mater or the philanthropy of her rich friends, has been generous enough to provide one or more rooms which are at the disposal of sick graduates—provided they are not already occupied. An alumnae association has a fund for sick nurses, with perhaps a credit in the bank of a few hundred dollars. These provisions are most valuable, but can we ever hope to see them a really powerful factor in the nurses' future?

How many women have taken up nursing, who are altogether dependent upon their own exertions for their immediate livelihood and also upon their ability to lay aside a few dollars for the time when they are no longer able to endure the physical hardships attendant upon the life of the average nurse? How many of them are helping at home to educate a brother or sister, or to take care of an invalid mother or father? What possibility can these hard-working women have to save, when the dollars must go out as fast, or faster, than they come in? But, I can hear you say, "Nurses are better paid than most bodies of working women—consider the wage of teachers," etc., etc. Consider the *life* of a nurse, the dangers that surround her every step of the way from the time she enters her training school until the last day of her activity in nursing interests! Her work is continuous, her hours are long and often the physical and mental strain excessive for weeks or months together!

A nurse that I knew was called to take care of a case of scarlet fever. She was unfortunate enough to contract the disease, and found herself unable to remain in her Alumnae Club House, and with no place to go. She was finally able to arrange for her admission to a large hospital where she was promised a room provided she would secure the services of two special nurses, so that the hospital would have no responsibility for her care. Weeks of illness ensued, and when finally she was able to be again on her feet, it was only to realize that her total savings of ten years had gone to defray her expenses. How many of you here this morning could duplicate this story? Looking about us to-day we see the nurse of ten years' experience receiving for her expert services the same remuneration that is paid the new graduate! In some places I know that a movement has been made to introduce graded charges, but it has been met with open opposition and severe criticism.



It has been but a few days since a friend of mine passed through New York on her way to Newport where she had been called to care for an ill baby. She had had some two weeks of a well-earned vacation, and was just about to enjoy two more weeks, when urgent messages called her to the home of this wealthy family. For years this woman has confined herself to obstetrical work, and so successful has she been, that the best known obstetrician in a large city calls her for as many of his rich patients as she is able to care for. She is the daughter of a clergyman, now dead, and she and her sisters must work for their living. She has been a sufferer with asthma, and may at any time find herself unable to earn another dollar. The doctor with whom she is so closely associated has himself made a fortune, is able to live in a fine house and surround himself with every comfort. When asked why she did not put up her rates to \$30.00 a week, her reply was, "Dr. ———— did not wish her to charge more than \$25.00 per week." The nurse who is on duty for from eight to sixteen hours a day in the care of a patient who does not hesitate to pay \$150.00 for one gown, and who, perhaps, through her able and continuous care has hastened the recovery and added to the patient's comfort, must be satisfied with her \$25.00 per week. Is this to be always so?

What sensible man would enter any field of labor with a certainty that however capable he might grow to be, the future held for him no financial betterment? Let us consider the possibilities in institutional life. Upon the ability of the superintendent of nursing depends, to a very great extent, the success or failure of her training school. Only through her unceasing vigilance and the power of her personality, will that school grow and develop to the best advantage. There must be no end to her versatility, her un-failing patience and tact. Late and early she must busy herself with the knotty problems that confront her, and her

most mature wisdom must be freely used in the cause of her employers. The next few years will see many women turning away worn out, mind and body, from the institutions which they have faithfully served during the very best part of their lives. What provision have they been able to make for their future? What must be the rate of interest on the savings from a salary of \$900 to \$1,500 per year that would begin to provide even the most humble livelihood for a few years of forced inaction? What can be the future of these women? I can see only one—a life of dependence upon a brother or sister, or some member of her family, or a burden on the community. I am speaking this morning to executives in hospital work. Is there a superintendent of nursing here who could honestly say that she has never admitted to her school, or graduated therefrom, any but most desirable women? What is the reason that we cannot secure better material? Isn't it possible that this very prescribed financial condition may have something to do with it? There are a few well-paid nursing positions, but so pitifully few, that the majority of nurses are about as apt to secure them as the ordinary citizen is to become the President of the United States!

Mediocre ability is to be found among nurses just as it is among other working people, and undoubtedly they are worthy of only mediocre reward, but it must take a dauntless spirit indeed to throw herself body and soul into any work when she knows at the outset that a few years of ill-paid service, however brilliant and valuable it may be, can only end (unless she is fortunate enough to die in harness) in years of dependence. Commercialism is to be deplored in the kind of work in which we are engaged; but, after all, one must have the dollars and cents if one would live. A nurse cannot be made of too good material! You and I are dependent upon her to care not only for us, but what means infinitely more, for our dear ones, when they

are ill or dying. Upon the refinement, the education, the tactfulness of these nurses we must place our confidence. We need a high type of woman in this work. How can we attract her? How can we make it possible for her to enter our ranks, knowing that therein she can find the possibility of an independence—not in luxury—that I do not expect—but in decent, honest ability to stand on her own feet, not only during the years of her greatest activity but when, through misfortune of any kind, she can be no longer a wage-earner?

I am not wise enough to solve this problem of the future of the trained nurse, but I am venturing to thus lay it before you, Superintendents, Managers, Trustees, that you who have the opportunity and the power to influence those who can better in some degree the lot of these women who are every day risking their lives in the care of suffering humanity may have a brighter outlook!

PRESIDENT: The subject of this paper is open for discussion. Does any one wish to say anything on that subject. The next paper on the programme, a very important one, is that of "Hospital Social Service." I might say that this Association for two or three years has desired to bring this subject before the Association as a matter of enlightenment to the members in the West and South who have had very little opportunity of knowing the details of the work. This is our opportunity.

## HOSPITAL SOCIAL SERVICE.

BY MARY E. WADLEY,

*Executive Secretary, Social Service Bureau, Bellevue and  
Allied Hospitals, New York City.*

A prominent physician was recently invited by a man who is recognized the country over as an authority in his specialty, to join forces with him in his well-known clinic. The invitation was one which many a doctor would covet, but it was refused, to the great surprise of the specialist, who asked a reason. "Because," said the other, "you have no social workers and I would never attempt to work again without one!" I think this reply voices the appreciation of all hospital men who have ever had the assistance of an efficient worker.

A young girl with chorea had long been attending a clinic without receiving any lasting benefit. A social worker was added to the clinic, and one of the first cases referred to her was this girl. The following was her illuminating report after investigation:—

"Name, Mary Jones. Age, 15 years. Diagnosis, chorea.

"Social History—Box factory worker. Hours of work, 9. Not employed for last month.

"Home, four-room tenement. Sanitary condition, fair. Bedroom ventilated with small air shaft. Gas stove used for heating and cooking. Lives with grandmother, brother and sister. Occupies bed with latter, who is restless, moans, throws off clothes, and walks in sleep. She and sister quarrel about these disturbances.

"Grandmother nervous and irritable. Brother teases patient about her nervousness. Patient sensitive about going among people.

"She seems slightly better since coming to clinic. Appetite good. Has stopped taking tea and coffee.

"Cot provided for her. Family instructed as to importance of ignoring her nervous condition.

"Later, Mary was sent to a convalescent home for four weeks. Has returned in almost normal health.

"Sister has been persuaded to come to clinic also."

Would bromides or Fowler's Solution have accomplished much in this case? And was not the physician's time and dispensary's expense wasted for months on that girl, just because no one had the time to investigate the social hindrances to her improvement?

Most hospitals regard with pride their yearly records of "recoveries" and their financial showing. Has anybody ever told us how many of the recoveries did not stay recovered more than a week or a month? Have we ever studied the actual meaning of "discharged improved" or "discharged cured" which cover the pages of our big record books?

Have we kept track of re-admissions? Had we the Central Hospital Registry which Dr. Goldstein has so urgently advocated, we could then learn how soon after having "discharged cured, Diagnosis, pneumonia," written on his bedside card, John Doe had a new card made out for him in ours or some other hospital, with the diagnosis tuberculosis—and all for want of an overcoat, perhaps, when he left the ward in the very early stage of his convalescence.

What becomes of Thomas Smith, the surgical case who was discharged as "improved," although still needing, perhaps even only slight, dressings, and who was told that he must return to the dispensary three times a week until his sluggish wound had completely healed. He had to go, for the wards were full, but he might as well have been told to go to the bottom of the East River and come up three times a week for air. Tom Smith is a single man who lives in a furnished room when he works, but his troublesome hernia had made his earnings intermittent lately, and he didn't give up until he had to. Room rent was overdue when he finally came to the hospital.

What awaits him as he passes out of the hospital gate with the prescription "Come back three times a week to be dressed"; that is, come back and wait in a line two hours, perhaps, for his turn to come in the crowded clinic? Even if he were able to work, what job could he get that would permit of practically three half-days' absences a week, and where is he to sleep and eat until his first pay day? The lodging house will take him for a night or two, true, but will the lodging house sleep and meals build him up very fast? Here we have a *vagrant* in the making—for how can he help going from bad to worse?

Or, by and by we get him with an infected or tubercular wound. Nobody wants to see him come back to the hospital—he is not an interesting case now. The chances are that he may become a public charge for the rest of his days, and all for the lack of a comparatively trifling extra care and expense at a critical time.

I recall now one actual case of this sort among many others. The patient was a decent, hard-working young fellow. When he was discharged with the direction "come every other day to be dressed," fortunately there was the Social Service office for him to turn to; he was sent to a convalescent home and otherwise assisted until he was well, for he was without funds, home, or friends in this country. This was three years ago. He promptly repaid his indebtedness, and frequently visits the office. He is very thrifty, is now married and has a home of his own, and is a good citizen. And this is not an isolated case in our experience.

The great awakening sense of social responsibility which is spreading over the world in these days, has reached the hospitals and is creating a new order of things there. Now, when the hospital, by medication, has relieved the cardiac's acute attack, for instance, it looks into his home conditions and the nature of his employment. If we find that his home is at the top of a tall tenement, we see the wife or



mother before his return home, and persuade her to look for the lightest, airiest rooms she can find on the ground floor, and we shall not stop with that *advice*, but if she has not the means for moving we will help her to secure them.

We must see the case through to a practical conclusion, for again half measures are a sheer waste. If the patient's former employment requires great physical exertion, our duty is not fully done until we have seen him installed in more suitable work, and supplied with good living rations until he has gotten fairly to earning. We may not need to do all these things for him ourselves, but we must see that they get done. Finally, we should urge him to attend our weekly evening class for cardiacs, that we may continue our oversight of him.

Maladjustment to home conditions—monotony—perhaps, of the all-work-and-no-play kind—worry—over-work, or lack of work—poor cooking or insufficient food—cheerless or unsanitary surroundings, hidden poverty, or unhygienic habits—often, to help a patient to change some one of these conditions will be to touch the button that will entirely transform the sick person into a well and normal one.

But who is to uncover the needs and work out the solution of such problems as these? The busy doctor and ward nurse cannot possibly find the time for it, however great their desire to do so; and besides, "everybody's business becomes nobody's business."

Mr. Homer Folks, in a public address, gave the best definition of our subject I have ever heard, when he said "Hospital Social Service is simply common-sense applied to getting the patients well."

If a sick man needs only milk, eggs, and fresh air; if a woman with varicose veins needs elastic stockings to help her; if the typhoid needs convalescent care to save a relapse; then does not common-sense say—for their own sakes, to save them from chronic invalidism; for the physician's

sake, that his gift of time and skill may not be altogether futile; for the hospital's sake, that its money for treatment and expert service may not be absolutely wasted; and finally, for the community's sake, that it may be protected from the contagion of disease, and that as many of its members as possible be kept in a condition of industrial efficiency instead of dependency—then does not common-sense say that there should be supplied the link between the patient and the possible resources that will make the doctor's advice feasible and the hospital's care effective?

Such a link is the Hospital Social Service worker, and the after-care she gives the patient may most accurately be termed *Hospital Extension Work*. That link is not wholly supplied by visiting nursing, nor is it relief work pure and simple, but a combination of the two which has created a new vocation—that of Medico-Social Worker, with an enormous field spreading out before those who adopt it for their profession.

In asking financial support, and even in admitting their patients, do not hospitals tacitly guarantee to do everything possible to effect a cure? If, then, the medico-social clinic and social workers are positively needed to that end, is it not the hospital's plain duty to establish and maintain that department just as much as it now maintains its drug store and its ward nurses, or its X-Ray room?

And this duty is not accomplished when a hospital accepts such a service from some philanthropic organization—the closest co-operation there must be with all such, but to accomplish the best work the impulse and directions must come from within the hospital itself—from its medical staff, if possible, or from its superintendent.

It is a *therapeutic* undertaking and needs medical understanding for its directions and execution, and as such should be dignified by being made a department of the institution—otherwise such a service must fail of its highest achievement.

All are doubtless familiar with the recent history of this movement, especially with that connected with the Massachusetts General Hospital in Boston. Just when the very first organized effort was made by the hospitals themselves to give this extended care to their patients is a mooted question, but, on a recent visit to London, I was surprised to find that the London Hospital in Whitechapel Road had been practicing Social Service since 1791, when one of its physicians, Sir William Blizard, formed a society to do just what we are doing to-day—only they did not call it Hospital Social Service. For the last twelve or fourteen years a nurse has been in charge of the work. She has now three assistants. They send convalescents to the country, and relieve the hindrance of social conditions for their patients, just as we are trying to do.

In America, since the issuance of the first report (for 1905) of the Massachusetts General Hospital (which report, by the way, is a classic on the subject and ought to be put into the hands of every worker, superintendent, or members of committee who contemplate taking up the work), great interest in the subject has been created, and forty or fifty hospitals have established the service.

Suppose we decide to establish such a department, how shall we go about it? some one may ask.

Each institution has to plan its own concrete scheme of work in accordance with the social status of its patients, and with reference to the efficiency or lack of the resources of its neighborhood. But there are definite aims which should be common to all Hospital Social Service, chief among which are these:—

1st.—To aid the physician in his diagnosis and treatment by investigation and relief of social conditions.

2nd.—To make available the philanthropic resources of the community, and to co-ordinate medical resources—for example, Eye, Orthopedic, Dental Clinics, etc., in restoring a patient to complete physical efficiency.

3rd (and not least in importance).—To carry the educational influence of the hospital to the homes of the community.

It may be of interest to some to hear what organization has been found practical in a large city hospital like Bellevue. Inspired by the Massachusetts General, Dr. Armstrong, the then Superintendent of Bellevue, with the approval of the Board of Trustees, established Social Service there in 1906. The salary of a nurse and a simple office equipment were provided by the hospital. Five months later an assistant was added.

At the end of eighteen months a strong Advisory Committee was formed to support and further the development of the service. This committee is made up of the representatives of the governing bodies of the hospital—the Trustees, Medical Board, Dispensary Board, Managers of the Training Schools, the General Medical Superintendent of the hospital, the General Superintendent of Nurses, the Chairman of Special Sub-Committees, with the head worker as Executive Secretary.

Bellevue has a thousand patients, many of whom represent the extreme of poverty. Social Service there is a gigantic problem to attack. We have not attempted to take up dispensary work, except for the children and the tuberculous patients.

In organizing the practical work the first step was to visit all the larger charitable agencies to establish a personal relationship with them. Making rounds in wards acquainted the physicians and nurses with the undertaking, and in that way the first patients were found. Now, at the end of five years, we have a large staff of workers, including one for each of the three allied hospitals, and the work has dropped into its natural divisions with special workers giving their exclusive time to each.

For example:—There is the General Welfare Division, and the Tuberculosis, Child Welfare, Psychopathic and Jewish Divisions, with small special sub-committees for each. We hope this year to add a special worker for following up the maternity cases.

We have the fullest co-operation with everybody connected with the hospital, and that, in itself, is a keen pleasure. Our hands overflow with the number of cases referred to us daily, and the diversity of problems seems almost unlimited, calling for every resource we can command.

The following case illustrates some phases of the general work:—

Two years ago a sick-looking woman came to the dispensary for treatment. The examining physician found her condition critical, and told her that if she would save herself she must come into the hospital at once for an operation. She assured him that that was impossible, for she had six children at home whom she could not leave.

That was too much of a problem for the doctor to solve, so he gave her a note to the Social Service office to see what we could do about it. In the note he stated that in his opinion the woman had not long to live unless radical measures could be taken at once.

I can never forget the drawn face of that woman as she stood at our desk after this interview with the doctor. She said that her husband had been killed in a street accident the year before. Since then she had, by day's work and the help of the 15-year-old boy, barely kept the family together; but recently she had been less and less able to earn. What she was going to do she didn't know, but of one thing she was sure—if she gave up and came to the hospital the younger children would have to go to institutions, and that she could not, *would* not consent to, for she could never get well with the thought of that in her mind. No, she would struggle a little longer—a suit was pending for damages because of her husband's death—she would wait and see.

We made her sit down and talk it all over. Soon a plan was evolved which allayed her fears, and infused her with new hope. We promised that not one of the children should be sent to an institution. There was an aunt who she thought might take care of the two younger ones. The eldest boy, who was of very steady habits, and the eldest girl of thirteen, would be quite capable with supervision, she thought, of looking after the others. A relief society agreed to pay the rent for as long a period as necessary, and we promised to send a woman for three half days a week to oversee the housekeeping, while a nurse from our office should call often enough to make sure that all was going well.

The mother entered the hospital the next day. The operation confirmed the original diagnosis. She barely lived through it, but at the end of three weeks she left the ward and was taken to a convalescent home, where it took nearly a month to repair the starved body and nerves, but when she did return to her family she was, indeed, a new woman.

A year later, on one of her frequent visits to our office, she said she had not felt so well since she could remember. A few months ago the long-pending suit was settled for \$50 a month for twenty months, so for the time, at least, the family is prosperous.

But for Bellevue having had Social Service workers, that woman would have gone home from that clinic that day and stayed there, and she would surely now be lying in Potter's Field, and our public institutions would be taking care of five orphan children.

There is a difference of opinion as to whether or not Social Service workers should have a relief fund of their own. We cannot see how efficient work can be done without an emergency fund. The case above cited is of the sort which justifies it. The Society to which we applied helped with the rent, indeed they helped for a year, but



stated that they could not send a woman in for the house-keeping. For us it was a comparatively small expense, and it helped another widowed mother who needed the work. Had we not had the money in hand much valuable time and effort, which rightfully belonged to other waiting patients, would have been used in trying to find some one who would have given it, and what difference did it make in this case whether it came from our hand or from some other, since there was no question of both the immediate and ultimate good which it might accomplish?

Is there not great danger of pauperizing? some one will ask. With common-sense at the helm, that fear is a bogey. Can it pauperize to bridge the crisis until earning time again, when one is on the edge of destitution? Indeed, *withholding adequate* help makes pauperization sure.

We all know there are two crimes which we workers may commit—we may demoralize the weak, or insult and crush the self-respecting. If we are unable to avoid either extreme, or if we cannot look beyond the temporary need of removing the underlying cause, we are unfit to be Social Workers.

Tuberculosis work is now so well understood, we need only refer to it here. With us, the principal features, in addition to the ordinary clinic work and regular district visiting, are:—

The Day Camp, which is an old ferry boat anchored in the East River just off the hospital grounds;

The Children's Garden in a corner of the hospital grounds;

The Intensive Class Work, with small groups for home treatment;

The Boys' Club, made up of boys from the families of tubercular patients;

The Mothers' Classes in Italian and German, held weekly by the Supervising Nurse, and

The Weekly Evening Conferences for working men.

The assistance of Social Workers from the Free Synagogue, consisting of several devoted volunteers, under the direction of Dr. Sidney Goldstein, has been of inestimable value to us for the last four years. Not only do they take entire care of those whom, because of their language and temperament, it is hard for us to help understandingly, and therefore adequately, but they are always ready to take a cordial interest in the whole work of the Bureau.

Each volunteer has assigned to her care the Jewish patients in certain wards. Every morning our registrar copies from the admission records the names of all such patients who have been admitted in the previous twenty-four hours, and when the workers come, as they do most faithfully on the three visiting afternoons of the week, they look over this list, and each takes care of all in his or her ward who may need assistance. They also furnish their own funds for relief, at the same time working in close co-operation with the United Hebrew Charities.

In the Child Welfare Work the sanitary conditions of the homes must be investigated, and mothers taught how to carry out the doctor's instructions, and if we ever have a large enough force to accomplish it, our *aim* will be not to lose sight of any child until it is made as physically normal as possible—that is, to persuade the mother to have imperfect teeth attended to at dental clinics, discharging ears treated, adenoids and tonsils attended to, and flat feet corrected, if possible. In short, to help the child to get started in life freed from every needless physical handicap.

In the Psychopathic Division we have the most serious problems, and therefore the most intensive work is needed.

Preventable insanity! How full of meaning is that phrase! Clinics may make the diagnosis and the prognosis, but who is going to give the poor, morbid, borderline case, who is not *yet* a "hospital case," the careful oversight that

is needed to keep her from slipping over the edge? Who is going to provide the rest, the change of scene, or employment needed to save her, or where is the wisely sympathetic *friend* who will instil into the discouraged brain the wholesome thought, "Happiness is a habit"—and help her to cultivate it?

Bellevue has a unique feature which few other hospitals have. Many sick prisoners in the city, including all attempted suicides, who are awaiting their preliminary trial before being committed to the City Prison, are sent from the station houses to Bellevue, thus necessitating the maintenance of prison wards. Here is where the Social Worker finds plenty to do—for many a one in these wards is in deep need of a friend—and in approaching them we need to bear in mind Thackeray's words—

"What right have you to be scornful whose virtue may be  
a deficiency of temptation,—

Whose success may be a chance?"

To come back to the practical question of how to start the work:—

The first step, pre-supposing the salary to have been secured and the physicians ready for it, is to choose a worker—and here I cannot better express my own ideal of what a Hospital Social Worker should be, than by quoting from an article by Dr. James Alexander Miller in the August, 1910, *Journal of Out-Door Life*. He says:—

"First, the woman herself. In order to make a success of Social Service, a woman must be endowed with more than the average ability, character, tact, energy and education. She must be quick-witted in emergencies, resourceful in difficulties, and persistent amid discouragements. As the *personal touch* with the individual is the main object to be obtained, a deep human sympathy which will invite confidence is of course essential, but this must be sympathy untinged with sentimentality. *Firmness* there must be, but

this must be combined with tenderness. In other words, we must have a *practical idealist* for this work. Such a woman as I have sketched is born, not made.

"Second, the nurse. A poor nurse will never make a good Social Worker, and conversely, every characteristic in a woman which makes her an efficient nurse will sooner or later find its proper expression in her social work."

He goes on to say, "I am not one of those who believe that it is an unnecessary luxury to secure a *nurse* for this work rather than simply a trained Social Worker without previous nursing training. The experience which comes from familiarity with the sick, the discipline of regular hospital work, the eye trained to observe, and the hand and mind to act quickly and skilfully, are all essentials to the highest kind of social service among the sick poor; *but, nevertheless*, it is not every good nurse who is fitted for Social Service work. The nursing qualities must be combined with the more purely womanly ones I have described, before it is safe for any one to hope that she would succeed.

"Third, the Social Worker. For the woman splendidly endowed by nature, and for the nurse fully equipped by training, there is still need of special education before she can become the successful Social Worker."

Happy will be the hospital who succeeds in finding such a worker! Having found her, and provided her with office room, telephones, etc., she may safely be left to work out, with the physicians, the problems of her particular field.

The greatest difficulty she will meet with in many hospitals will be that of convincing those in authority of the need of an assistant when she knows that the time has come when it is imperative for good work that she should have one. I know of two hospitals where social work has been a failure because of this difficulty. The workers have given

out under the strain of the accumulative care. An intelligent worker to stay in the office to answer telephones, see visitors, keep records, etc., would have saved the whole situation.

As the outgrowth of experience, it seems to me very important that those who are engaged in this work should have their residence away from the hospital. The work is so intensive, its fascinating interest so great, it will be likely to carry them far beyond their regular hours; the responsibility of deciding the vital questions for her charges that arise each day, puts an exceedingly severe strain upon the worker, which it will be hard for her to endure for any length of time unless she can get completely away from the hospital atmosphere at night—away from all temptation to “talk shop”—and into a place of more normal life wherein to regain her balance daily.

An extra holiday or two, now and then, is a very wise investment in the long run, and here is where those in authority need to do a little social service for their workers. It is unnecessary, and poor economy, to use up a good worker by long hours, just because tradition has fixed them for nurses.

In nearly all hospitals where Social Service is established, the office hours follow those of the Board of Health nurses and of established charities, i.e., from 9 a.m. to 5 p.m., with Saturday afternoons, Sundays and holidays off duty.

Salaries vary from \$1,500 to \$900 a year.

The supply of good workers is not nearly equal to the demand at present. It is to be hoped that training schools will remedy that situation soon by adding social work to their curriculum, or as an elective in an advanced course—for Social Service will soon be regarded as a fundamental feature of every up-to-date hospital.

As to *methods* of work. There is much discussion as to whether it should be done this way, or that way; but does not the criterion of success in anything lie in results, for surely results only justify methods. When you see the half-well made strong; the discouraged, down-and-out men or women raised through counsel or material assistance, if need be, to working efficiency; homes that were tottering put back on a more permanent foundation; and the puny babies turned into fat, rosy ones, then you may be sure that your methods are pretty nearly right, that you are indeed applying *common-sense* to getting people well, and you can go ahead.

There will be failures, of course, for no receipt can be found for completely making over human nature, or for curing all ills; but it is astonishing what results a sincerely sympathetic spirit of helpfulness, coupled with sane judgment, can bring about.

A worker must be an optimist—must keep the well of inspiration full by thinking most of the ones whom she knows she has really helped—their number will be the greatest, if she is made of the right stuff, and if her service is a genuine personal service. There is no place for a pessimist in Hospital Social work.

Workers will become dismayed, too, because they see so much to be done. And the little they can do, no matter how strenuously they strive, seems to be such a drop in the bucket compared with the overwhelming need. But if they will stop to think of the influence of that little upon Tom Jones, whose trend to the insane asylum they have helped to stop, and of what that means to his family, and, in concentric circles, to the community; and of what it means to the immigrant, whose burden of black despair was completely lifted when he was made to understand that the steamship ticket found in his pocket would be redeemed for a later date. (It represented all his savings of years in a



Montana mine, and was to have taken him back to his own kith and kin on the steamer which sailed last Saturday, had he not met with the accident which sent him to the hospital in the strange city Friday night). And of what it meant to the would-be suicide, who had decided after days and days of weary, fruitless search for work that the world did not want him, but who, when he came to consciousness on a hospital cot, found a new friend who knew how to patch up the broken strands so the seam would scarcely be noticed, and who knew of a new pathway which would lead out into a larger life than he had ever known;—and of what that little meant in the lives of the children, who would likely have been motherless to-day but for their efforts;—if workers will stop to think of a few achievements like these, their courage will return, for they will feel that any one of them was worth even months of labor. It required only a “hand’s turn” from them, and yet how heavily fraught with consequences to the whole future lives of those concerned!

In the name of the thousands of patients whom this audience represents, I beg you to try the experiment of Social Service in your institutions. If it is not possible to get the Hospital Board to appropriate the salary, is there not some friend of the hospital who would furnish it for six months to demonstrate the value and need of such a department? If you get the right worker, and the right medical direction of the undertaking, there will be no doubt of its continuance. It will add something to your budget, but it will surely reduce your per capita cost to the community by preventing recurrent cases, and your bank account in the saving of human happiness will be a wonderful one.

# OUTLINE OF THE WORK OF THE SOCIAL SERVICE BUREAU OF BELLEVUE AND ALLIED HOSPITALS, NEW YORK

## EXECUTIVE COMMITTEE

Representing Hospital Board of Trustees, Department of Public Charities, Hospital Medical Board, Dispensary Medical Board, General Medical Superintendent, General Superintendent of Nurses, Board of Managers of Training School, New York City Visiting Committee, Chairmen of Sub-Committees, Executive Secretary

## ORGANIZATION

HEAD WORKER: Executive Secretary, Bellevue Hospital

OFFICE STAFF: \*Assistant, Registrar, Messenger

PHASES OF WORK	GENERAL WELFARE DIVISION	CLASSES OF PATIENTS
<b>PLACING IN CONVALESCENT HOMES</b> Securing admission Obtaining clothing Providing railroad fare Restoring afterward to self-support	Special committee Two salaried workers	<b>HOMELESS</b> Temporary care Employment Loans until pay day Referring to societies
<b>PLACING IN PERMANENT HOMES</b> Incurables      Deaf mutes Defectives      Soldiers Epileptics      Aged	<b>TUBERCULOSIS DIVISION</b> Special committee Eight salaried workers	<b>IMMIGRANTS</b> Reassuring through interpreter Communicating with friends Exchanging steamship tickets Securing assistance through consuls, etc Accompanying to homes or friends
<b>PLACING IN REFORMATORY AND TEMPORARY HOMES</b>	<b>CHILD WELFARE DIVISION</b> Special committee Three salaried workers	<b>BOYS</b> Advice Home correspondence Employment Preventive work
<b>HOME VISITS FOR INVESTIGATION</b>	<b>*MATERNITY AND PEDIATRIC DIVISION</b> Special committee One salaried worker	<b>CRIPPLED CHILDREN</b> Referring to Children's Aid Society for special schools. For conveyance to and from school and for country in summer Braces, etc.
<b>SECURING TEMPORARY CARE FOR CHILDREN WHILE PARENTS ARE IN HOSPITAL</b>	<b>PSYCHOPATHIC DIVISION</b> Special committee One salaried worker	<b>DESERTED OR UNMARRIED MATERNITY CASES</b> Referring for employment with child Legal aid
<b>CARING FOR THE TUBERCULOUS</b>	<b>JEWISH DIVISION</b> Special committee One salaried worker Volunteers	<b>PRISONERS AND ATTEMPTED SUICIDES</b> Friendly interest Referring to probation officer Accompanying to court Assisting in readjustment to life
<b>SECURING AID FOR DESTITUTE FAMILIES BY REFERENCE TO RELIEF SOCIETIES</b>	<b>ALLIED HOSPITALS</b>	<b>ALCOHOLICS AND DRUG HABITUES</b> Counsel Referring for special treatment After care
<b>FOLLOW-UP WORK FOR CHILDREN</b> Instruction in home and individual hygiene	<b>HARLEM HOSPITAL DIVISION</b> Special committee One salaried worker	<b>NEURASTHENICS</b> Change of environment Change of employment Friendly oversight and direction
<b>CLASS WORK WITH CARDIACS</b>	<b>FORDHAM HOSPITAL DIVISION</b> Special committee One salaried worker	<b>INSANE</b> Aid by investigation before committal Referring for after care
<b>AID TO EMPLOYMENT</b>	<b>GOUVERNEUR HOSPITAL DIVISION</b> Special committee One salaried worker	
<b>SECURING LEGAL AID</b>	<b>AIMS</b> To aid the physician in his diagnosis and treatment by investigation and relief of social conditions and hindrances. To make available to those who need assistance the philanthropic resources of the community. To coordinate resources of special clinics—for example, eye, orthopedic, dental, etc., in restoring patients to complete physical efficiency. To carry the educational influence of the hospital to the homes of the community.	
<b>SECURING SURGICAL APPLIANCES</b>		
<b>LOANS</b> Accompanying to } homes } trains } court		
<b>SENDING MESSAGES TO FRIENDS</b>		
<b>SECURING DENTAL TREATMENT</b>		
<b>INVESTIGATION FOR IDENTITY OF UNKNOWN</b> Cooperation with other social workers regarding patients in Bellevue in whom they may be especially interested		
	* Asked for 1912.	

PRESIDENT: I should like to say to the many guests who are present that they are invited to take part in the discussion of this paper, and any of the other papers that are presented here to-day, or later. We hope to hear from many of them. The guests have the privilege of the floor. The discussion on this subject will be opened by Miss Louise C. Brent, of the Toronto Hospital for Sick Children.

MISS BRENT: Anything I can say in connection with this paper will be absolutely futile in regard to the commendation of the work that is done by Bellevue and Allied Hospitals. It is something that is beyond compare. I only wish to add this, that in our small way in Canada we have started this work. We are very, very far behind, but we have made a beginning. If the superintendents of the hospitals who are here will realize and bring it before their boards of management, that they are saving the hospital money by having a social service worker, they will certainly do something. In our hospital, especially within three or four years ago, I can verify what Miss Wadley says, that it has been of inestimable benefit, both to the community and the hospital. Looking at it from an entirely selfish standpoint, it has been found that we are saving money. The patients are now discharged very much earlier and are looked after in their homes by this nurse. Of course, we do not pretend to do the work that is done here, but we have simply made a beginning, and I think that possibly in the smaller hospitals and with people in the smaller cities, that it can be done even in a small way with benefit to the community and to the hospital itself. With regard to the pauperization of the people, that is absolutely an absurd idea, because, as Miss Wadley has so ably presented it, if we are turning these poor unfortunates into healthful citizens, we are certainly saving the community, and we are not doing them anything but the greatest benefit. Dr. Babcock asked me to discuss this paper. I had very great hesitancy, because I am not a speaker, but I simply wish to endorse everything that Miss Wadley has said. In Canada, I think there are only two hospitals that have the social service, the hospital at Winnipeg—I think the Superintendent is here—and our own hospital. Of course, there is social service work done by district nursing and by our grand Victorian Order, but we are the only hospitals I have been able to find anything about. Before sitting down, may I thank Miss Elliott for her valuable paper.

Seems to me there are dozens and dozens of us that would like to have said something on it, but our natural timidity prevented us from doing so.

DR. FISHER: We at the Presbyterian Hospital, are very enthusiastic about our small department of social service and visiting nurses. I think Miss Wadley very completely covered the ground. I did not quite hear all, owing to bad acoustic properties. There is one phase which comes to me very strongly. Our President has sometimes suggested that perhaps we ought not to limit ourselves to a district, which we can cover, not only to care for the patients, but to follow them to their homes and to do the educational work which is necessary. It is not always easy to get into the homes of the poor people to show them better conditions. When strangers come in, they are met with suspicion, but when the member of the family has been in the hospital and the nurse whom they have seen about the hospital, who has come into the ward to see them before they are to go out, and we have to say to the patient, "We cannot keep you any longer, you are not as well as we would like to have you, but we will send a nurse to see you from time to time and keep in touch with you and see that the conditions which are necessary for your recovery will follow you into your home," the door is open for the nurse to come in. And if that nurse is the right one, as Miss Wadley has described, and has the tact and the teaching ability, the opportunity for education in that home is very, very great, and I know from what I have learned from our nurse that there has been a complete change in many homes, a change from unsanitary conditions, from dirtiness to cleanliness, not absolute, but people have been given new ideas and they have taken to them and they have made an effort, they have appreciated what the effort of the nurse has been, and then we have been able to get patients out in the convalescent homes very differently from what they used to do. It is all very well to tell John Smith that if he will go down to a certain office on Second Avenue and see the people there, that they will arrange for his going next day to some convalescent home, but I tell you when John Smith gets home from his hospital and has to walk a long way, he is too tired to walk in the next day and he does not get out to the convalescent home and he stays in the unsanitary conditions of his own home. But when the nurse visits him and finds out something about the home, and he suggests he has not got the clothes, she says she will come to his home and talk to his wife and family and she will look

out for him, and attend to all the business and take him next morning to the station, go with him, the problem does not look so large to him. He goes directly from the hospital to the station, they take a carriage, if necessary, or go together on the cars to the convalescent home, and so the mental activity which tires out the patient is taken away and they go. It is very pleasant to have some one say, "Come with me and I will look out for you." Much pleasanter than it is to say, "Go there and do that." And so through our social service and our visiting nurses, we are getting people out to the convalescent homes, and then when our nurses come into these homes of the people, they discover there are other members of the family that need a lot of attention and they need to go out in the country; if they go into the country, they will not have to go to the hospital, and so our nurses are getting people from their homes directly into the country, just as Miss Wadley has shown, but that introduction to the home comes because the nurse has been in contact with the patient in the hospital.

MISS TIPPETT: I cannot add very much to what has already been said. The patients that are already in the hospital are received in the ward, my work is simply to refer them to the proper agency. I cannot very well visit them in their own homes. I get reports from the various agencies that I have referred them to. In some cases I have been able to help them get work. It is extremely interesting, one feels that it has great possibilities. There is one thing that I think has not been mentioned, and that I have found frequently, and that is that it is not only the very poor that need social service, but I think sometimes the better class. Most of the speakers have referred to those who are entirely without means, or very poor, but there are a great many people that need help and advice that are not very poor, as far as this world's goods go, but they need help in perhaps buying new clothes, they need direction, and that I do not think has been spoken of, and I do find that quite often amongst the people that are better off they do need help and encouragement and all that sort of thing.

DR. SYDNEY GOLDSTEIN (Director Social Service, Free Synagogue, New York): It was said by the President that it has taken the American Hospital Association three years in order to get the subject upon the programme. I think that is because a prophet is never honored in his own country. This subject is really six years old, and should have come before this audience and before this Association long before this. You also said that



the subject has been introduced in order to arouse interest in the South and in the West; there are also some hospitals in the East and in the North that ought to be aroused upon a subject of this kind. Miss Wadley has mentioned the work that the Free Synagogue is doing at Bellevue Hospital, and as the result of that work we have learned a number of things that might be of interest to the members of this Association. It ought not to be necessary to plead this subject for a very long time, it ought to be evident to everybody, even to managers of hospitals, that there is something more to a sick man than his sickness, it ought to be evident that there is a wife at home, that there are children at home and that in some cases there is the man's immediate future to be taken care of and that the man is not always able to take care of his future, that he is not always able to take care of his wife and children, but he is sick in the hospital. The majority of our patients who come to our institutions come to us from a class that is always walking upon the verge of dependency, they are able to earn nothing more than their daily livelihood, they are not able to save up any money for a spell of sickness. The result is that when they come into the institution, they leave their families practically destitute, and unless something is done to tide over this family over this period of temporary distress, the probabilities are that this family will gradually drift into destitution. Social service that deals with these problems will prevent a great many people from becoming applicants for charity or becoming dependents upon the community. We have learned in our work that the family must be considered a unit of treatment. It is absurd to consider the patient the unit of treatment when sickness is the cause of trouble in the family, the family is a unit of suffering and all our relief organizations understand that it is a family that must be dealt with and not an individual. You have a man in your hospital who has pneumonia; how is it possible to expect that man to recover in the way in which you would like him to recover if he is constantly harrassed by the fact that his wife and children are at home suffering, that they are without food, that the rent has not been paid, that they are without any of the things they absolutely need. The very thought of his wife running around to the organizations for help is quite sufficient to retard the man's recovery, so that it is necessary to take the family as the unit of treatment in so simple a case as that. It is necessary in more complex cases. If I may cite one example of a young girl with heart trouble. This girl, the doctors find, is in a condition that can be



relieved by a few weeks in the hospital, but they send her home and they tell her that she must live in light, cheerful rooms and must not run up and down stairs. But the social worker finds that the family has been living in a dark, damp basement, that the father of the family is unable to provide any other habitation for his children, how are you going to expect this girl to be cured of her heart trouble, or relieved permanently.

I want to take up the second principle that Miss Wadley has touched upon, namely, that social service must be prompt and must be continuous. Those of us who are in hospital work ought to realize that the admission to a hospital is not the beginning of the case, it is merely the climax of the case. Men and women do not want to go to hospitals and they do not go until they are compelled to go, and they do not go without much hesitation and without many misgivings, and so it is necessary to meet the patient immediately upon admission so as to relieve the patient's mind of all distress regarding his wife and children, or the mother regarding children who have been left at home. Not only should the care be prompt, it should be continuous. The visitors should visit the patient constantly in the ward, because sometimes you will find, as we have found frequently, that the patient will not have need of assistance during the first week, or even the second or third week, but during the fourth week it is quite possible that the patient will call you to his bedside and confide to you with tears in his eyes that the children are in need of food and the wife is in need of rent, otherwise she will be evicted. Then we have learned to establish this principle for ourselves, that a case is never closed until the patient and the family have been socially rehabilitated. I remember in looking up some case in a charitable organization that I ran across, one typical of all the rest, the case of a young girl who had developed tuberculosis. She was taken to a sanitarium and as soon as the admission was made, in large red letters there was stamped at the bottom of that card, "Case closed." You know that case is not closed, and no case is closed until the family have been socially re-established. I am afraid too many people look upon the hospital as the mere reception house for the sick, as a place in which nurses and physicians can secure the training which they desire and nothing more than that. The hospital was originally organized as a social institution and it ought to become so again. It is necessary that the hospital should recognize its social duty to the patient, as well as a medical duty to the patient. I mean by that that the hospital ought to admit

as an integral part of itself the Social Service Department. It has been difficult to convince boards of trustees and to convince superintendents that this is a part of hospital work. Social service ought not to be the part of an extra institutional body such as the Free Synagogue that comes into the hospital in order to give the special care which otherwise is lacking. Social service ought not to be part of a work of a department that is loosely attached to the training school, the hospital itself ought to recognize this as a duty and ought to admit it as a part of itself. That is done, I believe, in Buffalo Hospital, which I visited last year, it is done in Mount Sinai here, and in probably one or two other cases, but the managers of hospitals are very loth to recognize this as a part of their work and superintendents are also hesitant to admit it as a part of the hospital proper. All our popular institutions are being socialized, and the hospital cannot escape. I want to tell you a story that I think will illustrate it better than anything else. Dr. John Dewey, Professor in Columbia University some years ago, told a class a story about a miller who had a mill to sell, and set a ridiculously low price upon the mill, and the people were very suspicious and did not want to buy the mill. At last one of his friends went to him and said, "Why is it you set so low a price on the mill? The machinery seems to be in good condition and the building itself is in good condition; what is the trouble?" "Well," he said, "it is quite true the machinery is in good condition and the building is in good condition, there is only one trouble with the mill and that is that the mill wheel is just about one foot above the water." That is sometimes, I am afraid, the trouble with the hospital, the mill wheel is one foot above the water, and what the social service is going to do with the hospital is to bring the hospital and society in contact with each other and make the hospital a real effective institution once more.

DR. WASHBURN: As Superintendent of the Massachusetts General Hospital and a member of the Advisory Committee on the social service work, I should like to add my evidence as to the great value that that work is to the hospital and to the community. There are two or three practical points which this matter teaches the executive of a hospital to which I would like to draw your attention. The first is organization. I thoroughly agree with Mr. Goldstein that the proper organization would be for the trustees to assume the burdens. I say "burden," I mean financial burden of the social service work, that it should be directed

through the executive of the hospital, advised by a strong advisory committee, of which committee the executive of the hospital is a member, with members of the staff of the hospital, the head of the Social Service Department, and perhaps certain social experts connected with other schools if they work in the community, or ladies and gentlemen of means whom we can hope to interest. A second point which comes to my mind is the question of the connection of the training school with the social service work. That has been brought to my attention several times and I thoroughly believe that it is most important that the social service worker should have thorough training. I believe that the trained nurse, all things being equal, makes the best social service worker, but just what shall we do if your nurse has not the qualification? It would not be desirable to add it to the curriculum unless we have arranged to have it an elective in the last six months of the last year and only for those specially qualified and interested take this work. Or is it wise to make it post graduate, and after the nurse has had her three years' training, been out in the community perhaps, and knows what private nursing is, to come back and take a course of training as a social worker? I am rather inclined to think at present that the last is the desired course. The supreme importance of training in social work before responsibility is placed upon the social worker was brought to my attention by an incident of which I know where an enthusiastic social worker not connected directly with the hospital came to the superintendent of one of our hospitals and said to him that she would like to get access to the records of the genito-urinary department for men in the out-patient department, because the organization with which she was connected intended to follow these men into their homes and see what could be done to remove the evils and limit the danger. The superintendent replied he did not find he was at liberty to give her access to such records, because he felt that there was another side to that. The danger was that if it should become known amongst the people in the community that such information was given out by the hospital, that men in distress under those conditions, would avoid the hospital and fall into the hands of quacks and medical institutions. Just the remedy for that, the proper half-way course I do not know, but I believe there is that danger, and a hospital superintendent would be wise to keep it in mind.

MR. DANIEL TEST (Penn. Hospital, Philadelphia): I can only take a moment of your time, but the question seems to me so important that I want to lend my endorsement to it. We established a social service department two years ago, and the wonderment to me, after observing it a little while, was not that social service departments were only started six years ago, but the wonderment was that it had not been done sixty years ago, for the aid to the hospital work in general, to the patients and to the hospital officers, is very great. I will just refer to the question that Dr. Washburn has spoken of, that it seems to me very important that this department should be under the supervision of the executive of the hospital, and to be supervised by a committee of the managers and their workers, and in reference to its relation with the training school, this may be a suggestion. At the beginning of this year we called for volunteers from our undergraduate nurses offering a six months' training and supplying them with room and board. We at once had more volunteers than we could take on duty, and I think that in the future we can have perhaps all the assistance that we wish from our training schools, and the applications come from women who are interested in the work and adapted to it.

DR. LINDSEY: As a director of one of the New York Schools of Philanthropy, I might say a word in this discussion as to what you could expect from these schools and from social workers in general in the way of co-operation in securing efficient service in the social service department of hospitals. I will not attempt to argue the question of the desirability of social service in hospitals, I take it for granted that you will not have any difficulty in convincing managers of hospitals that social service is a necessary part of hospital service. But securing properly trained workers is a matter that interests training schools for nurses. I think you will have no difficulty in communities where there are not organized training schools, for the social workers in giving their active co-operation. We have been sending our students for some time to the hospitals for practice work, and we have arranged a special course somewhat along this line: Not too many lectures, not too much work that is not directly connected with the demands of the social service department of a hospital, but something to acquaint the students with the point of view of the social worker and to give students information with regard to the charitable and social resources of a community. We have, for example, arranged a four months' course, consisting of two lectures a week, by

Dr. James Alexander Miller, of Bellevue Hospital, on the social aspects of disease, and a course of two lectures a week by Miss Richmond, of the Russell Sage Foundation, with the assistance of two other workers, Mrs. Quinn and Dr. McLane, on the subject of family rehabilitation. I have a standing offer, and I think I can extend it beyond the limits, I made an offer, I think, to the sixteen social service departments in connection with the hospitals of New York City that if the superintendent in charge of the hospital would send to us a worker who was a member of his regular staff, whom he would give leave of absence or leave of duty sufficiently so that they could take this work, we would be glad to take them without charge of tuition and give them the four months' course, letting them go back into the hospital, we think, somewhat better equipped, perhaps, for the special work of the social service department. That offer is still standing to the superintendents of social departments in New York City, and I think would be extended elsewhere if the circumstances seemed to make it desirable to do so. I simply mention these facts for the purpose of bringing to your attention in this discussion the fact that there are special training schools for social workers; there is a growing demand for social work in all directions, and those who are interested in these schools and those who are interested in training school workers are ready to meet you half-way and co-operate with you in building up and strengthening the special service department of hospitals.

MR. ELLWOOD (State Charities Aid Association): My experience in social service work has been limited to social service work in connection with the insane. About six years ago the State Charities and Aid Association started under the inspiration of Miss Louise Lee Schuyler, to do this kind of work with the insane. An agent was employed who had training as a nurse and who was also a graduate of the New York School of Philanthropy, to devote her entire time to care for the insane who were discharged as recovered from the hospitals in New York City. I may say this work has grown very successful; it has increased from year to year, and I might also add that a large part of the success of this work has depended to a great extent upon the ability and training of Miss Martin, who is the agent and has superintended the work right through. This is not a success only in connection with after-care work, as it is impossible to engage in after-care work without doing preventive work, and in fact, what is after-care work but preventive work? It is nothing more than prevent

ing a second attack. In a year or two the name of the committee was changed to prevention and after-care, and last year the committee was reorganized and enlarged. Active work was begun a year ago for the prevention of insanity. The plan was to devote a large percentage of time and energy to the work from an educational standpoint, to acquaint the people of New York City to which our field is limited with the present known causes of insanity. This educational work has been done in various ways. We have issued a little pamphlet whose value is dependent upon the fact that it is endorsed by eight of the most prominent psychiatrists. These pamphlets have been distributed through New York wherever it is possible to make efficient distribution. In addition to this we made use of the press by newspaper and magazine articles and stories, also made use of public lectures. These lines of work will be continued. In addition to this, the lines of work along the line of publicity will be extended. In addition to this educational work, we have endeavored to establish more out-patient departments and more clinics, where the poor people afflicted with approaching insanity may go and receive competent advice.

DR. BORDEN (Fall River): I think the value of social service departments to small hospitals in provincial towns cannot be too much emphasized. From the point of view of the management of the hospital, if the management is able to raise \$1,500 a year, it cannot be better invested than by starting social service departments. In the larger cities where charities are organized, there are generally some means provided for all the difficulties that flesh is heir to; in the smaller towns there is not the scientific care of the badly-off that there may be in the larger cities. In the first place we want to get a good social worker, because a good social worker can conserve and put together all sorts of unused energy and see that it is applied in the right direction in the smaller towns. As an illustration, we have patients that we want to send out to farm houses and the question of transportation comes up. There are plenty of automobiles in the smaller towns and a social service worker has at her disposal a large number of automobiles which can be used for the benefit of her poor people. It is not simply the question of using the automobile, the minute she begins to use an automobile to convey a poor convalescent to a farm house, the very fact of the use of the automobile appeals to the lady to whom the automobile belongs and when she tells her husband it immediately appeals to him that that is a pretty good way to take care of indigent people, and the result is that you are



making friends for the hospital in a way that you never could otherwise. But you must not make a mistake in thinking that when you employ a social service worker that you are solving the problem, you are getting new problems, and a hospital would not be any fun unless you are getting new problems all the time. The social service work provides certain kinds of work for tubercular cases. For instance, lots of these women who are quite able to use their hands never have been taught plain sewing, and they can do that perfectly well if only shown how. They are shown how, not by the social service worker, but some lady in the community to whom she says, "Won't you teach that poor girl to sew up a hem?" or whatever it is. Now, I just want to say this to encourage those who are interested in small hospitals to start in on social service work, do not let the big institutions have all these institutions. We can do it to fully as great an advantage, that it is a good business investment for the management to hire a social service worker and appropriate a fund for that work and the hospital will be better off financially two years hence than it was before.

Adjourned till 2.30 p.m.

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## THURSDAY, SEPT. 21—AFTERNOON SESSION.

PRESIDENT: I will appoint as a committee on commercial exhibits, as decided in the resolution this morning, Rev. Dr. Kavanagh, Dr. Frederick A. Washburn, of Boston, and Miss Lina Lightbourn, of Syracuse. This committee is to report to-morrow morning. This afternoon we have a programme on which each individual speaker is an expert in his field of work on the subjects that are allied to hospital work, some of them quite directly pertaining to hospital work.

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## HOW TO INCREASE PUBLIC SUPPORT OF HOSPITALS.

BY FREDERICK D. GREENE,

*General Secretary, Hospital Saturday and Sunday Association of New York City.*

Historically hospitals had their origin in the grace of hospitality, the kindly treatment of the stranger, or *hospes*. Later they received only the destitute sick. Now they have become human repair-shops for the whole community, treating the ill and injured both among the poor and the rich.

### MOTIVES FOR HOSPITAL SUPPORT.

Hospital support at first was all voluntary and given from religious motives,—love to God, love to man, gratitude for blessings, penance for sin. These are among the highest springs of human action and it is to be hoped they will act with unabated force to the end of time. There is every reason to suppose that the author of the Good Samaritan parable assumed all these motives.

Other motives for hospital support have been called into action by changes in living conditions, by a better understanding of the infectious nature of disease and of the vast economic loss which it entails. These motives should not displace those of religion and philanthropy, but working in harmony with them should on grounds of self-interest, sound business, and good citizenship secure, through taxation if necessary, such additional support as to promptly and adequately meet the needs of the whole community both in the treatment and prevention of disease.

### SOURCES OF HOSPITAL SUPPORT.

Hospital support at present comes from the three following sources, which affect each other, and should therefore be considered in any effort to secure increased hospital funds:—

- 1.—Patients who pay for service to themselves.
- 2.—People who, as of old, contribute for the benefit of others.
- 3.—The community which, on grounds both of self-interest and of humanity, aids with money raised by taxation.

Hospitals may be maintained by one of these sources or by the first two, as is the case in London, but the ideal way would seem to be a combination of all three. The majority of the non-municipal hospitals in New York City are at present receiving this triple support with the approval both of city authorities and representative philanthropists.

#### PAYING PATIENTS.

In regard to the first source of income, the patients themselves, it is fair to say that the failure of a hospital to collect from people able to pay is to be condemned, because it exerts a demoralizing influence upon the recipients themselves, because it curtails, to that extent, the service which might be rendered to people in greater need, and because it tends to check benevolent gifts.

Without expressing any opinion as to the extent of the abuse of hospital privileges, it is suggested that much can be done to check it by requiring applicants for treatment at less than cost to fill out a blank giving such significant facts as residence, address, occupation, weekly income, monthly rent, number and ages of the members of the family. The mere requirement of this information would deter many improper cases from asking free treatment, and it would enable an intelligent inspector to readily form a fairly just idea of the merits of each case. Judicious investigation, where called for, could remove further doubt. A system like the above was lately adopted by a hospital, which during the preceding year, had collected only \$700.00 from its patients. The first eight months of its operation showed receipts of \$8,000.00 in cash, together with other indirect results of perhaps greater value.

The writer would suggest for large cities a joint investigating and registering agency for the confidential use of hospitals as a practicable and economical means of ascertaining proper free cases. Indeed, the machinery for this purpose is already available, at least in part, through the associated charities which exist in many cities. Closest "team-work" is called for in winning the fight against ignorance, pauperism and disease. Here is a chance to show it. The same public supports the Charities and the Hospitals; the same men are on their official boards.

In New York State the law makes it a misdemeanor to give false statements to a dispensary. Why is it not even more important to protect hospitals from such imposition?

#### PUBLIC FUNDS.

Passing over for the present the second source of hospital support, voluntary contributions, let us briefly consider the third—public funds raised by taxation.

Away back in the sixteenth century, when hospitals were being opened throughout Europe, Shah Abbas, of Persia, was asked why he did not establish some. "Hospitals would be a shame to me," he replied, "for where the government is good, there will be no poor, no sick." This answer shows at least a clear perception of the principle that it is a function of government, whether vested in the people or in a monarch, to remove the causes of disease, and that, so far as it fails to do so, it should bear the burden of its failure. If an Asiatic ruler four centuries ago, could take this ground, how much more readily should we, who know that the community, more than the individual, is responsible for the spread of disease, that the community and not the individual, has the resources for successfully combating it, and that the economic loss is as real to the community, as to the individual. Why, then, should we not look forward to the day when facilities for health of body shall be as

abundant as for training the mind, when hospitals shall be as free as now are the Public Schools or as fire and police protection? Long steps have already been taken in this direction and the trend is that way. If damages can be collected for a broken leg due to a defective city pavement, why not for typhoid due to a filthy water supply, or to careless milk inspection?

There is no stigma of charity attached to free Public Schools nor would there be in the case of public hospitals were they on the same basis. Moreover, the obstacle of expense being removed, people would more promptly place themselves under medical care and thus insure a more speedy and economical cure.

It is to the interest of the whole community to keep everybody well. It is to the interest of all good doctors to be kept busy all the time, and to have the bad ones eliminated along with the bad medical schools, for which Dr. Flexner tells us the hospitals are largely responsible. Larger State control might do much to improve these conditions.

The health risk now falls often with crushing force upon the innocent. The assumption of this risk by the community would stimulate it to reduce the risk to a minimum, by checking the causes that fill hospitals. It would mean a new impulse to the departments of health and of housing, of factory inspection and of street-cleaning, of medical care of school children, and restriction of child-labor.

If these considerations seem foreign to the subject of this paper, they have been introduced just in order to emphasize the importance of taking a broad and non-partisan view of the problem.

#### VOLUNTARY CONTRIBUTIONS.

Let us now return to the second source of hospital support, voluntary contributions. While it is not desirable that private charity should relieve either individuals or the com-



munity of burdens which properly belong to them and which they are able to bear, this principle should not be so interpreted so as to embarrass the millionaire—the morning paper says there were sixty of them on the disabled Olympic—who finds himself in at least legal possession of vast wealth, and who wishes to avoid, as one of them expressed it, the “disgrace of dying rich”—or of dying without making an intelligent and equitable disposal of his property.

There is no need of regarding the accumulators of great fortunes as either “pirates” or “hogs.” As a rule they are men of great ability and of decent habits. They *must* be. Business has been to them a football game into which they have gone with all the frenzy of a college boy. Unfair advantages have sometimes been taken and foul blows dealt, but the evil results are as much due to the faulty rules of the game and to the cheering crowd as to the players themselves. The faulty rules are being rapidly corrected by legislation, and if the average man and woman will show a good example in their own ideals, and methods of attaining them, the pitiable millionaire, and his more pitiable descendants may become a thing of the past.

What should guide the wise philanthropist in the process of restoring to society surplus wealth, in the production of which, he will recognize that his fellowmen, and a bountiful Creator have had a larger part than himself. He will reserve his aid first for those who really need it, and second for the discovery and solution of unmet social wants, thus blazing a path in which the city, state and nation will follow as soon as the public is sufficiently educated and aroused. General education has been enormously aided by the benefactions of the rich, whose attention may now well be turned to problems of physical well-being in which hospitals play so large a part.

## FACTORS THAT DETERMINE HOSPITAL SUPPORT.

The amount which a man, whether rich or in moderate circumstances, will give for hospital support depends:—

1.—Upon his understanding of what a hospital *is*, why it *needs* support, and how *much* support it needs.

2.—Upon the character of the appeal, which should be convincing and significant as to facts, tactful and persuasive in form, timely and regular.

3.—Upon the auspices under which the appeal is made.

## AID OF THE PRESS.

Perhaps the newspapers are the most important and most neglected channel for cultivating increased hospital support. A two-inch paragraph inserted in a New York daily by the writer, led to a hospital contribution of \$20,000 from an entire stranger within 24 hours, and ultimately to one of half a million dollars. The picture of Smiling Joe which went all over the land is known to have inspired bequests to hospitals with which he had nothing to do.

The press forms public opinion in any case, and unless enlightened it is a serious obstacle to progress. A hospital official cannot spend time to better advantage, therefore, than in helping a reporter or an editor to get a clear and sympathetic idea of hospitals which will give higher social value to all his writing. As a rule there is no class more ready to take the right point of view when given the facts.

A sense for news and a knowledge of the channels by which publicity may best be gained, is a most valuable part of the equipment of any social worker and may well be cultivated by all. This is distinct from the ability to write up a subject with just the form and flavor demanded by the press. The latter is an art in itself. It requires a lightness and freshness of touch that is hard for one absorbed in his task, to command. An expert may well be paid for such work.

Important announcements, discussions of policy, financial statements and formal appeals should be carefully prepared by those in charge of the work, and given to all the papers simultaneously.

It is unfair to expect space to be given to items that have become stale or that never had news value. On the other hand, incidents in themselves trivial, are often so unusual, humorous or pathetic as to gain insertion, and may serve as a peg on which matters of real significance may be hung.

Photographs are a great aid in securing publication of articles and in adding interest to hospital literature, which, by the way, should not be criticized from the standpoint of medical etiquette, governing the private practice of the physician. The methods used by the Children's Hospital of Toronto might profitably be studied by others.

#### WHAT A HOSPITAL IS.

It is of the greatest importance that the public should be educated regarding the four main functions of hospitals, which are as follows:—

- 1.—Care of the ill and injured.
- 2.—Clinical training of doctors and nurses.
- 3.—Popular instruction in hygiene, the care of children and home treatment,—a large and legitimate sphere of hospital extension, recently discovered through the Social Service Department.
- 4.—The gathering of such data regarding the nature and causes of disease as will advance medical science and also provide a scientific basis for social and legislative action. The unique opportunities of hospitals to collect these facts, constitutes an obligation which they should be eager to fulfill, and which might well be required by law.

While the first of these functions, on account of its more immediate and personal nature may impress most strongly

the average contributor, the last four functions should powerfully appeal to people of large means and presumably of large vision, because they are of great strategic value in the warfare for health.

#### CO-OPERATION IN RAISING FUNDS.

The presentation of the appeal, whether to the small or to the large giver may be done either by each hospital for itself, or through a representative agency, or better still by both working in harmony. It is desirable that each hospital should be free to present its own claims, and should have an official board, who will work heartily for its financial success. Inasmuch, however, as there is a unity in the hospital problem of every large city, it is also desirable that there should be an organization intermediary between the hospitals and the public, loyal to both and so constituted and administered as to secure as large a charitable income as possible, and to attend to its distribution according to the needs and merits of each hospital. Such an organization, if non-partisan, non-sectarian and efficient, is calculated to render a service which is not within the power of any individual hospital in educating the community, in calling out its resources, and in furthering economy in management and co-ordination of effort among the hospitals themselves.

#### HOW LONDON DOES IT.

The highest development of co-operation in raising voluntary gifts for hospital support is to be found in London and is worthy of careful study by every American city. An idea of the size of London's Voluntary Hospital problem,—and it should be remembered that these hospitals receive no aid from taxation,—is given by the following figures, compiled by the Metropolitan Hospital Sunday Fund.

The figures are for 125 hospitals and 59 dispensaries with a bed capacity of 11,358 and a total of 125,053 in-patients treated, and of 5,912,326 out-patient attendancies.

. The income of these institutions for current purposes in 1909, was:—

Patients' payments . . . . .	£85,691 =	\$414,744 =	9%
Proprietary (investments) . . . . .	265,590 =	1,285,455 =	29%
Charitable . . . . .	572,502 =	2,270,910 =	62%
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Total . . . . .	£923,783	\$4,471,109	100%

Of the charitable income about 55% was sent by contributors directly to the hospitals, and 45%, about £250,000, nearly a million dollars came through the three great Hospital Funds, which, though independent, do not conflict as they each appeal to different elements in the community, and work in harmony in the distribution of money raised.

#### THE HOSPITAL SATURDAY FUND.

The Hospital Saturday Fund, formed in 1873, has collected since that date £549,186. It binds together the middle and working classes in the conflict with sickness, sorrow and death. Its annual income, amounting to £35,000, is collected from about 7,000 firms, from every trade, from friendly societies and clubs, from employees of railroad, telegraph and telephone companies, of the post office, fire and police departments. Collections are made mostly by penny-a-week collecting sheets paid quarterly, and also by boxes placed in factories and stores. Street collections were discontinued in 1897.

Groups which contribute £1 or more are entitled to elect a representative on the Board of Delegates, which manages the work through six committees, which in turn hold frequent meetings and are reinforced by an army of voluntary workers. This amounts practically to a form of hospital insurance, as the various groups are entitled, in proportion to their gifts, to "letters" of introduction to hospitals. It will be noted in passing that the name "The London Hospital Saturday Fund" has reference to Satur-

day as the common pay-day and not to Synagogue collections, which, with those of all other religious bodies are sent to the Metropolitan Hospital Sunday Fund, of which the President and Treasurer is the Lord Mayor.

#### THE METROPOLITAN SUNDAY FUND.

This Sunday Fund received last year from collections in 2,130 religious bodies, £40,778, and from legacies and interest, £30,773; total, £71,550.

In the multiplicity of sects it is certainly an inspiring spectacle to see these 2,130 religious bodies—Protestant and Roman Catholic, Jew and Greek Orthodox, Established Church and Dissenting, Quaker, Unitarian and Agnostic—all, pouring their offerings into the treasury of a common humanity without reservation, designation or distrust.

#### KING EDWARD'S HOSPITAL FUND.

King Edward's Hospital Fund for London was founded at his suggestion, while still Prince of Wales in 1897, in commemoration of the Diamond Jubilee of Queen Victoria. Starting under such distinguished auspices, the Fund has commanded the confidence and hearty support of the upper classes and people of means.

During the past fourteen years King Edward's Fund has raised and distributed £1,288,916 at a cost of less than 2%. The receipts for 1910 were:—

Subscriptions and donations .....	£62,696
Legacies .....	32,941
Income from investments .....	76,935
Gifts to capital account .....	32,596

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Total receipts for year ..... £205,169

It is interesting to note that the raising of these large sums has not diminished the income of the two older Funds nor the amounts which are still sent by contributors directly to the hospitals.



## EFFICIENCY AND ECONOMY PROMOTED.

Moreover these three Funds acting in concert and in friendly consultation with the hospitals though independent of them, have succeeded in,

1. Introducing into all the hospitals a uniform system of accounting and of statistical records by which it is possible to estimate with justice the relative "needs and merits" of the various hospitals.

2. In effecting economies of management, which during 1905, in the case of sixteen hospitals, amounted to £21,000, and in 1906, with 48 hospitals, of an additional reduction of £18,000 per annum.

3. A third great service rendered by these Funds is that they check injudicious schemes by requiring that all hospitals which expect aid from the Funds submit for approval in advance all plans involving new buildings, changes in location or in scope. By rendering these great services the confidence of the public has been so secured that many large bequests are being now made to the Funds by people who feel that thus their benevolent purposes will be most wisely accomplished.

Why should not the army of small contributors in every large city have an agency which will do for its gifts what the Carnegie Foundation does for Mr. Carnegie,—guarantee the most effective use of the money?

## NEW YORK'S HOSPITAL PROBLEM.

The following facts are of interest in showing how the burden of caring for the ill and injured in New York City is distributed.

The Municipality aids, first, through hospitals under its own management; second, by making a per capita allowance to voluntary hospitals for the "public charges" which they treat. The latest figures available show that the following hospital patients were treated:

Department of Charities, 1909. . . . .	31,187
Department of Health (contagious), 1908. . . . .	9,695
Bellevue and Allied Hospitals, 1910. . . . .	48,573
	<hr/>
	89,455
Public Charges in Voluntary Hospitals,	
1909 . . . . .	16,877
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Total cases treated at City Expense.. 106,332

The City does not pay the full cost of public charges in Voluntary Hospitals, but makes a daily per capita allowance for medical cases of \$1.00, for surgical cases \$1.10, for chronic cases 45c., for children 40c., and for maternity cases \$18.00, for delivery and convalescence.

#### VOLUNTARY CONTRIBUTIONS.

As to the support of voluntary hospitals, the writer is convinced that there is a much larger, popular participation than is generally supposed. A study of the current income of 36 hospitals for the year 1910 shows no less than 31,470 contributions sent by individual givers directly to these hospitals amounting to the sum of \$865,157.57. Of these contributions 4,839 were from \$1 to \$9, 19,883 from \$10 to \$24; 4,454 from \$25 to \$49; 669 from \$50 to \$99; 1,598 from \$100 to \$249; 189 from \$250 to \$499; 75 from \$500 to \$999; 107 from \$1000 up. There should be added to this number probably 10,000 contributions sent directly to other hospitals, making a total of over 40,000. From this number there should be subtracted about 5,000 from people who have sent more than once, leaving approximately 40,000 individuals giving directly. In addition to all these, there is a very large number who have given in smaller amounts in collections of various kinds.

#### HOSPITAL SATURDAY AND SUNDAY ASSOCIATION.

We come now to the Hospital Saturday and Sunday Association of New York City, through which the good people

of New York have contributed \$114,000 during the fiscal year about to end on September 30th. This is an increase of about \$24,000 over last year and as it cannot be attributed to improved business conditions it argues well for the vitality of the organization and the possibilities of its still greater usefulness. The expense of the Association for thirty years have been only 5.4 per cent. of the amount raised.

The current annual expenses of the forty-five New York voluntary hospitals belonging to the Association, not to mention other hospitals, exceed their annual income from invested funds, from paying patients, and from city appropriations by about \$1,500,000. This must be secured from voluntary contributions, the raising of which is a serious burden and expense to the hospitals. As far as they can be relieved of this burden, it would be to the advantage both of the hospitals and of the public.

The membership of the Association consists in one representative from each of the forty-five associated hospitals and about an equal number of members at large, selected citizens representing the contributing public. Hospitals that apply may be elected for membership in the Association, after due investigation and recommendation by the committee on admissions. The distribution of funds raised is on the basis of the certified number of days of free hospital treatment given by each hospital during the preceding year.

The Association had a local origin in 1879, but was influenced, no doubt, by the similar organizations started in London six years before, which suggested its name. The name, however, seems now unfortunate and is not recommended, as it conveys no meaning to strangers who should be interested, and as it is misleading regarding the methods now employed. There is, in fact, no Saturday<sup>\*</sup> collection in New York, for, although the Hebrews are among the most generous supporters, their gifts are made individually or are voted from synagogue funds. Moreover, there are prac-

tically no "Saturday" collections from wage-earners as in London, for two reasons,—because the population is too heterogenous and shifting, and because the facilities for free treatment both by the city and by voluntary hospitals are so great as to make letters of introduction of very much less consequence than in London.

As to the term "Sunday" it is a fact that less than one-quarter of the receipts of the Association now come from religious organizations. Though church collections were all that were sought at the outset, the arrested development of this phase of the work may be explained in part by the heavy demands upon the churches of their own distinctive activities, and also by an unfortunate holding aloof on the part of certain churches in the fancied interest of their own denominational hospitals.

The bulk of the Association's present income is from individuals who are reached by mail and from auxiliaries in the various trades, professions, exchanges, and among women, which canvass their respective members by subscription lists or by mail. The efficiency of these auxiliaries varies greatly according to the interest taken by those in charge and the nature of the business.

Trades which lack organization or natural unity do not form successful auxiliaries and are better reached by appeals directly from the Association. Auxiliary leaders, who are influential, loyal and energetic deserve the hearty thanks of the community and should find satisfaction in a service which means much more than the amount of money secured. Such leaders, however, are not easy to find and may drop out at any time. The Association should, therefore, cultivate as close relations as possible with all contributors, so that too much may not depend upon the personality of individual workers.

Contributions from over a thousand firms show that business men are impressed with the value of a representative organization for the economical raising and equitable division of hospital contributions.

During the year ending September 30th, 1910, the forty-five voluntary hospitals belonging to the Hospital Saturday and Sunday Association, of New York, gave a total of 2,068,102 days of hospital treatment, of which 1,235,524 were free. They treated 36,957 patients entirely free, 23,400 public charges for whom the city paid about half, and 28,509 who paid for their own treatment in whole or in part, making a total of 88,863 patients. In addition to this 490,712 cases were cared for in the dispensaries of these hospitals, involving 1,417,490 visits by patients.

The income of these hospitals was as follows:

From the Hospital Saturday and Sunday Association .....	\$84,835.82
City Appropriations (per capita) .....	561,325.55
Paying Patients .....	1,255,663.26
Income from Investments .....	962,827.71
Other Receipts, except for Permanent Funds ...	1,203,073.16
From Dispensary Patients .....	200,612.28
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Total Income .....	\$4,358,337.78
Total Expenses .....	4,416,846.04

#### PATERSON GENERAL HOSPITAL.

The General Hospital, of Paterson, N.J., furnishes an interesting example of what may be done through a so-called "Saturday and Sunday" Hospital Organization by an individual hospital.

It has an auxiliary consisting of about 100 young men, who are divided into committees which in 1910 obtained the following results:

240 Mills Contributed .....	\$4,458.21
80 Fraternal Organizations and Societies gave	856.53
57 Churches and Sunday Schools.....	1,170.71
93 Stores and Firms .....	419.71
36 Organizations, Churches and Individuals in Neighboring Townships .....	414.71
Miscellaneous .....	89.35
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Total .....	\$7,399.06

This is a substantial help to the hospital and was collected at a cost of only 6.7 per cent., but it represents a large amount of effort, both by the chairman and the numerous assistants that had to be secured and instructed.

The justification of the effort expended is largely in its social and educational value. Hundreds of wage-earners who would otherwise have given nothing, have gained a more intelligent appreciation of the hospital as a factor in the life of the city.

The 200 young men were made better citizens by rendering this civic service. The chairman himself and others have become interested in learning the causes that send people to the hospital, and as a result a thorough social survey of Paterson has been undertaken that may lead to large results.



PRESIDENT: The discussion will be opened by Mr. Gill.

#### DISCUSSION

MR. CHARLES A. GILL (Germantown Hospital, Philadelphia): Our President, Dr. Babcock told me yesterday that he thought I might mention some novel schemes resorted to in Germantown for raising funds. In Mr. Forbes' paper yesterday mention was made of several successful efforts, there was one omitted, however, that I believe merits mention, known as a thank offering for well children. Placards were placed in the store windows announcing that on a certain day the following week men and women, lovers of children, were to be asked to contribute a penny a week for the endowment of a bed. It is needless to say that within a fortnight more than enough was raised to endow the bed. In our children's ward we have a tablet in recognition of this effort "In memory of or endowed as a thank offering." We do not claim originality in this effort. I believe these various schemes are better left to the individual hospital. I quite agree that patients should be encouraged to pay something toward their support. The ease with which many hospitals admit patients free of charge only tends to humiliate and pauperize. Usually the friends of the patients are able to pay something, and if such payment is observed, it is often the very link which preserves a patient's friendly feeling for the hospital. I believe the same holds good with regard to patients receiving treatment in the dispensary; except in rare cases they should be required to contribute an amount at least sufficient to pay the costs of medicine and supplies. There have been several occasions in our hospitals when we found bottles of medicine thrown behind bushes and trees, and I have investigated those cases and found in every case they were bottles given free of charge. Patients do not throw bottles of medicine away that they are obliged to pay for. Letters of appeal are, in my mind, among the most dignified methods for securing hospital support, but to get the full benefit they should be followed up by hospital representatives. I called on a gentleman recently who had persistently failed to respond to such letters. He acknowledged receiving them and said he had fully intended a contribution, but for some reason had neglected it. I received a substantial contribution from him at that time. In regard to grants of public funds, assuming that a state or municipality is responsible directly or indirectly for a large proportion of the injury or sickness of its poor, it would seem entirely reasonable to urge legislation providing for taxa-

tion based on the extent and character of hospital service rendered. I believe there should be a specific rate for certain patients per day, payable after careful audit by the authorities. From what I have heard from Mr. Green's paper I believe New York has a very equitable method of distributing public funds for hospital purposes. At each session of the State Legislature from five to six million dollars is appropriated to privately managed and favored hospitals, almost regardless of service rendered. In conclusion, I should like to say a word in regard to internal organization. I believe one of the most valuable assets in securing and maintaining public support is training and perfect internal organization. We, as superintendents, must realize that that is largely our responsibility. It is true that we have many demands made upon us largely by people unfamiliar with the real purpose of the hospital. These demands should be met firmly and courteously, any individual antagonism or discourtesy may be interpreted by the public as mismanagement and the withdrawal of public support must be expected. Keep down complaints, in time it is bound to react for the support of the hospital. In regard to newspapers, I believe it is always best to treat them liberally and to give all proper information freely. By giving proper information it will do away to a large extent with the sensational and weird stories we read about in our local papers.

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## HOSPITALS, MEDICAL EDUCATION AND RESEARCH.

BY MR. ABRAHAM FLEXNER.

*Carnegie Foundation Hospital, New York City.*

Hospitals cannot subserve the purposes for which they are established unless well-trained doctors can be found to man them. Well-trained doctors must be educated largely in hospital wards. If hospitals do not afford medical schools abundant facilities for clinical instruction, the hospitals must find themselves unable to discharge the function for which they exist.

We may then set this down as our first point: Unless medical schools enjoy free and untrammelled use of abundant hospital facilities, medical students cannot be properly educated, and both the hospitals and the public will suffer from the lack of competent physicians and surgeons.

Does this mean that special school hospitals must be generally established? The problem is one that requires careful consideration in the light of our national attitude towards hospital and educational endowments. Colleges and universities operate over so extensive a field that they are nowhere regarded as merely local institutions. Money for their support is therefore available from many widely scattered sources. Hospitals on the other hand are regarded by philanthropists and benefactors as distinctly local affairs. It is held to be the business of every community to look after its own wear and tear in human life. Money to endow and support hospitals must therefore be procured from the community in which the hospital is situated. Philanthropists in New York and Chicago will not give money to endow and carry on hospitals in Philadelphia and Omaha. If, therefore, special hospitals must be provided for medical schools, the money with which they are to be created and supported must be obtained from the community in which the hospital

and medical school are situated. In addition to the hospitals already maintained for charitable purposes in New York, Chicago, St. Louis, Detroit, a new set of hospitals likewise supported by local subscription would have to be created for the purposes of medical education in these various cities. This is in the first place an absolutely impossible undertaking as things now stand; it is, in the second, quite unnecessary.

Well, if we cannot hope to support special hospitals for medical schools and if medical schools cannot be effective without abundant hospital facilities, it follows that a working arrangement must be arrived at between existing hospitals, public and private, and medical schools.

Does this mean that all hospitals that happen to be located in towns where medical schools are found are in duty bound to put their wards and dispensaries at the service of these medical schools? By no means! The medical school has obligations and responsibilities that are just as definite and unescapable as the duties and responsibilities of the hospital. Before a medical school has any right to ask any concession or privilege whatsoever from a hospital, it must be in position to demonstrate that it is prepared to make a wise and effective use of what it asks for. Before the hospital opens its wards to educational use, it not only may, but must satisfy itself that the medical school applying for its privileges has, in the first place, enrolled a competent student body; that it has provided adequate facilities for instruction in the underlying medical sciences, both in the way of laboratories and teaching staff; and that it is prepared to take upon itself whatsoever financial obligation is incurred by introducing teaching and research into hospital wards. The school must bear an equitable share of the cost of a proper pathological department; it must support clinical laboratories in which students may learn and practise the technique of clinical microscopy, and, in general, it

must be prepared to pay whatever further expense is entailed by the application of modern methods to teaching medicine. Wherever medical schools are in position to comply with these conditions, the hospital can only be improved by close and liberal affiliation with them. Wherever medical schools are unable to comply with these requirements, they are entitled to no educational privileges or facilities whatsoever.

Our modern hospitals in their dealings with medical schools have almost without exception done too much or too little. They do too much when they offer facilities for amphitheatre or other clinics, however meagre, to medical schools that enroll an incompetent, immature, untrained, miscellaneous student body, who, on the basis of a shaky grammar school education have received a perfunctory training in anatomy and physiology. Anything a hospital does for such a school is too much. They do too little for schools that carefully sift their material, have small student bodies made up of intelligent and competent students who have already received in the medical school good fundamental training in the necessary branches. For such schools the hospital can hardly do too much. In my judgment, the hospitals should do practically all, or they should do nothing. By lending scanty privileges to unfit proprietary schools they have helped to perpetuate the worst educational regime in medicine that is to be found in any civilized modern state.

I will, with your permission, give a few examples by way of illustrating what I mean. The City of Chicago has in the Cook County Hospital a clinical mine of enormous wealth. There are in the City of Chicago two, perhaps I may say three, institutions, the enrollment of which is of good quality. Two of these schools, Rush and Northwestern, provide their students with good fundamental training in anatomy, physiology, etc. To these two schools the facilities of that great hospital ought to be liberally opened. There are, however, simultaneously, in Chicago other schools, one

of them a night school, whose students are the most miscellaneous imaginable,—the Bennet College, the Medical Department of the University of Valparaiso, etc., none of which has a decent student body or is in position to give such students as it has a decent training in the fundamental medical sciences. They ought, therefore, to have absolutely no standing at all when they apply for hospital privileges. As a matter of fact, the poorer and worst of these schools can take students into the rooms of the Cook County Hospital if a staff physician is in its faculty. The Franklin Square Hospital, in Baltimore, is open to students of the wretched Maryland Medical College. Grace Hospital, in Detroit, offers clinical facilities to the unspeakable Detroit Homeopathic Medical College. In the same town the Harper Hospital helps the feeble Detroit College of Medicine and Surgery to go on. The Maine General Hospital, in Portland, aids and abets the weak medical department of Bowdoin College. The Buffalo General is affiliated with the feeble so-called medical department of the University of Buffalo. This list might be indefinitely extended. The instances which I have given are, however, sufficient to illustrate the point that I have made. None of these combinations is educationally or ethically justified. The trustees and managers of the hospitals involved would be doing humanity a service if they absolutely shut down altogether on the teaching use of their facilities by the schools named. The schools could not survive the blow and the general level of medical education in America will rise only as schools of the type in question are suppressed. On the other hand there are excellent institutions that deserve greater facilities and privileges than they now get. The affiliation which has lately been arranged between the medical department of Columbia University and the Presbyterian Hospital of this city, like the affiliation previously arranged in St. Louis between the projected Barnes Hospital and the re-



constructed medical department of Washington University is a model which ought to be followed wherever a medical school adequately financed and conducted on high lines is casting about for adequate accommodation in hospitals for clinical teaching; it ought to be followed promptly and gladly in a few places where at present the clinical privileges enjoyed are far below the deserts of the Medical School. I may mention as an example New Haven, where the Medical Department of Yale University is entitled to far more than it now gets from the New Haven Hospital. The same holds of the reorganized Medical Department of the University of Pittsburg in relation to the existing hospital of that city: in no other way can the public get well-trained doctors; in no other way can the hospitals get competent doctors and competent internes. Public interest and self-interest combine in urging the policy that I have advocated: large privileges to the deserving, none at all to the others.

I have said that the hospital does both an ethical, an educational and a professional wrong when it permits a weak or vicious medical school to hold even an amphitheatre clinic once a week within its walls. On the other hand, hospitals do ethical, educational and professional wrong when, given a medical school competently and intelligently conducted, the hospitals hamper them in the introduction of effective teaching methods. I cannot pause now to describe in detail what these methods are. It will be enough to say that students cannot be trained in the technique of scientific medicine unless they actively participate in the conduct of hospital service. If the hospital possesses an adequate staff, if the medical school possesses a competent body of clinical teachers, which we are here supposing, then the patients in the wards can, under discreet management, only benefit by the active participation of well-trained students in their care. The medical student must have easy access to the wards:

he must be charged with the responsibility of continuously observing a small number of patients assigned to him, under the constant supervision of the proper staff officers; he must have a place in the clinical laboratory where he can make the requisite examinations; he must, in a word, throughout his clinical training go through the motions of physician and consultant.

Medicine is a matter of doing, rather than mere knowing, and the medical student can learn to do only by doing. If, therefore, hospitals are justified in affording any facilities whatsoever to medical schools, logic requires them to furnish such liberal and abundant facilities as will enable the medical school to give its students a training that accords with the requirements of modern medical science. Once more I repeat the hospital must do all, or it must do nothing; and it may do all, only for medical schools that are educationally and financially able to bear their proper share of the burden involved.

Even were the reforms which I have advocated carried out, even were hospitals to refuse all privileges whatsoever to weak medical schools and to offer much larger facilities to the better institutions, the situation on the clinical side would in this country be still far from ideal. With few exceptions medical schools would still find themselves compelled to appoint to clinical professorships local practitioners previously appointed to positions on hospital staffs. It is perfectly clear that as long as this is the case, the clinical end of medical education will continue to be on a proprietary basis. Men engage in the practice of medicine and endeavor to develop large and prosperous practices. One of the means to this worldly end is a hospital appointment. I have no doubt that excellent service is often rendered by these appointees. Quite aside from that aspect of the question, however, it is obvious that if hospital appointments have a worldly value and medical schools in choosing clini-

cal teachers are restricted to such hospital appointees, clinical teaching will continue to be exploited for the worldly ends of practicing physicians and surgeons.

When once our hospitals have got to the point of making close affiliations with medical schools of high ideals, they must, in my judgment, be prepared shortly to go a step further. An arrangement must be worked out by which the medical school can have large scope in the selection of its clinical teachers, to whom the hospital privileges must thereafter fall as a matter of course. The medical school must ultimately get a potent voice in choosing the hospital staff. The hospital on its side can improve its service by requiring that the medical school associated with it be in a position to pay adequate salaries to its appointees. This is precisely what has been done in St. Louis and will have to be done everywhere if our medical schools are to become modern scientific educational institutions.

The imagination of a reformer should perhaps not endeavor at this moment to go any further. We are so far from the condition which I have just indicated as desirable that it may seem madness even to desire anything more. I believe, however, it may do us no harm to face the full truth. Clinical teaching is bound to retain a more or less proprietary character, it is bound to belong to a different category from other teaching of university character so long as professors of medicine and surgery can, in virtue of their school titles and places earn huge annual incomes. It is no secret that the professorship of medicine or surgery in a University Medical School to which a salary of a few thousand dollars is attached may directly and indirectly earn for the incumbent anywhere from twenty to fifty thousand dollars a year. It is obvious that under such circumstances teaching is only an incident. It is not the main occupation. Strictly taken, all clinical education in America is of this proprietary type or worse. I look forward to the day when we shall have produced in America a race of physicians and

surgeons who are interested in medical science and medical education and who will devote themselves to both upon precisely the same terms as now obtain with physiologists, anatomists, mathematicians and linguists. I see no reason why a professor of psychology should get \$5,000 in a university in which the professor of medicine can earn \$25,000. And if psychology is so absorbing and difficult a subject that it can enlist and indeed requires the total energy and devotion of the psychologist, assuredly the teaching of medicine and surgery in combination with the proper conduct of a hospital service are amply capable of consuming the time and energy of a single individual. We are not then going to expel the proprietary spirit and the proprietary motive from medical education altogether until hospitals permit medical schools to select their staffs on the basis of merit wherever they can be found, and require medical schools to possess resources enough to finance the undertaking.

This programme must of course be realized, if at all, step by step. The entire country is not at this moment amenable to uniform treatment. We are destined for many years to come to deal with a heterogeneous situation in medical education. Progress is undoubtedly making. Twenty schools perished during the last year. Mortality at that rate may be safely continued for the next four or five years to come, and it will take place if the hospitals now yielding grudgingly inadequate facilities to weak medical schools deny them altogether. This step at least could now with perfect safety be carried out in every section of the country. At the end of this highly desirable purgation we should have left about thirty medical schools, which would doubtless have improved considerably in the interval. Proper financing of this reduced number of institutions on such a basis as would warrant the intimate relations I have here indicated would not be an impossible undertaking; but the first

step towards it is to define in the eyes of the public the indisputable and fundamental requirements that must be made upon every medical school, viz., that it enroll only students who have definitely complied with an adequate standard of admission; that it provide laboratories and teachers for the fundamental branches; and that it make itself financially responsible for whatsoever additional expense hospitals may be called on to undergo in order to offer proper teaching facilities.

I have, for the sake of simplicity, spoken of education and entirely omitted research. But practically the same considerations apply to both.

Let us deal with this aspect of the question in all frankness. Research is nowadays a word to conjure with. Our American universities, colleges and technical schools have the word research emblazoned in bright letters on their banners. No doubt to research and to the products of research modern science must look for every improvement that is hereafter in store for us. But the qualifications which ought to characterize the investigator are by no means common. The cost of proper support of investigation is very great. The accommodations, laboratory and other, which research nowadays requires are certainly comparatively scarce. We have, therefore, the spectacle of research by men who have small qualifications therefor, in institutions which would do better to concentrate their resources on modest, but effective teaching. Under ideal conditions—if, for example, our hospitals were richly supported, and if their physicians, surgeons and internes had uniformly received a good medical and scientific training, it might well be that every hospital in America should in some measure contribute to the progress of medical science and knowledge. But to be perfectly candid, those conditions do not now generally obtain. Our hospitals are usually pinched for funds for current use. They are in many cases hardly



keeping up with the quick growth of population. Our medical men have, for the most part, received only an inferior medical education; our medical graduates now making up the residential staffs are, for the most part, still in pretty much the same case. It is idle to think that these men can, as a class, make valuable or important contributions to medical knowledge. They would do far better for themselves and for their patients if, by industrious reading, they appropriated results elsewhere obtained under more favorable circumstances. There may be, of course, individual exceptions to this generalization; certain hospitals may be able to afford good research departments: by all means let them do so. Nothing in my argument prevents a competent man with ideas, wherever he may happen to be, from doing all that in him lies to discover truth and to advance progress. But, on the other hand, nothing in our present situation would warrant us in trying to make hospital research a general and universal characteristic of American hospitals as now conducted and manned.

On its institutional side, research must for the present continue to be largely the responsibility of the few higher grade medical schools that I have described. The hospitals that are justified in furnishing these medical schools with educational opportunities must be ready also to create the conditions under which their professors and advanced students may carry on productive investigation. The financial burden of such productive investigation ought to fall for the most part, where the financial burden of chemical, physical, mathematical, or linguistic research falls—on the university; and universities which are unable to support medical schools of this type have no business to meddle with medical education at all.

In point of principle, therefore, the difficult situation with which you ladies and gentlemen are dealing is really simple enough, when you remember that a few leading



questions addressed to the faculty and trustees of a medical school will elicit the information upon which you can base a wise decision as to your possible relations to it. You must ask to see the kind of students it undertakes to train; the laboratory equipment in which it proposes to give them their fundamental training; the teachers who are to carry it on; and the funds applicable to teaching and research in both the fundamental and clinical branches. Where a medical school shows itself aware of its responsibilities on all these points, and capable of squarely meeting them, it is, I believe, your obligation as managers of hospitals, to go the full length in enabling the school to give its students the sort of clinical training I have above outlined and to enable the teachers to carry on productive labors in behalf of scientific progress.

I am not blind to the perplexities in which the execution of even this moderate programme will land some of you who are now managing hospitals open to one or more medical schools; but whatever your embarrassments, you cannot escape your responsibility. Your hospitals are mothering proprietary and unconscionable medical schools. Every indictment of an incompetent doctor is an indictment of the school from which he got his degree; of the teachers who pocketed his fees; and of the hospital which went through the form of offering him clinical opportunities.

PRESIDENT: We all admire a man who hits out straight from the shoulder; we love a fighter. Dr. Flexner published a report under the auspices of the Carnegie Foundation nearly two years ago, which brought down about one-third of the medical profession upon him. Those of you who feel hurt at all by his reflections on your hospital have an opportunity to get back at him; I am sure he will waive the ordinary privileges of a guest and take what is coming. I will ask Dr. Howard to open the discussion.

**DISCUSSION.**

DR. HOWARD: I have not read all the report to which you refer, but I did read a large share of it, and I felt as though that report was one of the epoch-making books that had been published during the last ten years. There are some points that I do not entirely agree with. Mr. Flexner speaks about research work being connected with medical schools. I had a few years ago a trustee who took this position, that all research work in regard to disease should be conducted by the hospital, that was the proper place for it, the hospital should hire these expert investigators and it should attract the money to the hospital to hire real expert investigators, that the business of the medical school was simply to teach what the hospital had worked out. He was perfectly willing to admit that the hospitals had never done it, but he said that is the place. That is the place where you get the expert who is anxious to study, who is anxious to work out his problem, he should no more be saddled with having to beat chemistry and other things into the heads of the students than this man whom Mr. Flexner has just spoken of as getting \$50,000 a year from private patients. He pretends to be saddled with teaching, we know he does not teach, we know he is after the \$50,000 and does just as little teaching as he can. We have met him, we have met others like him. I verily believe that if the principle could be inculcated so that the hospital would attract money to itself and get funds enough so that the hospital would do the investigating, that we would make faster progress in the science of medicine, so far as it is a science, than medical schools will ever make. Five years ago I had a man in view that was just thirsty for work in connection with fevers and all acute diseases and simply wanted to get in close touch with physicians who got close to their patients, all he wanted was that he might have sufficient guarantee that he could support his family, he cared for nothing else. That man was deflected from that work because a big institution wanted him to teach chemistry. He had no taste for teaching chemistry, but he was forced out of the problems that he wished to be a factor in solving by the very men, it would almost seem, who were trying to help him. There is nothing like a hospital if it can attract money to pay such a young man and give him a laboratory in close connection with his patients, I believe there is nothing like a hospital that can speed his work along in investigation. If he gets his results and makes them plain, the medical schools will teach them all right. There is another point on which I thoroughly agree with the line of argument that was brought out, and I would go a step further. I believe

that the time will come when these young men that are studying medicine will prize the place that the ward tenders now fill. I believe the chance that the ward tender has and that the nurse has to get next to the patient and to observe carefully, will be appreciated some time in our large hospitals and will be filled by the best students that we have. I believe that the very best part of my education was gotten in the four or five months' work that I put in in the hospital at Tewkesbury. At that time they could not hire ward tenders and nurses on account of the investigation that Gov. Butler was carrying on in that State. There was a notice posted at the Harvard Medical School, asking if there were not students there that would volunteer to come up and fill these places until the investigation was over. James Babcock, who is now the Superintendent of the Insane Hospital at Columbia, South Carolina, and myself, went up there, and, although I do not disparage or belittle the opportunities that Harvard Medical School gave me, I do feel that I would not swap those four months for any one year that I put in in the study of medicine, for the closeness of touch and the chance to observe. You know how awkward people are in handling patients. It has been such a relief to me all through life to be able to show a ward tender or a nurse how to handle patients so that they will keep the patient's point of view just a little to the front. There is such a difference in the way they do that work. I claim that that in certain cases contributes quite a little to the success of the physician. I suppose we are all glad to have the poorest medical schools, if they do poor work, crowded down and out, but there are men, you know, and probably Mr. Flexner could bring up a great many of them, that have started and got their inspiration and gone on, but the foundation in the first place came from these very despised places.

MRS. INGLEHART (Frances Willard Hospital, Chicago): I am from Chicago, and I am very much interested in this last paper, both personally and in other ways, because I am the President of the hospital that receives the clinical material from the College of Medicine and Surgery, and I can assure you that the hospital has greatly prospered and not suffered from receiving the clinical work from that college, and I ask you to investigate the standing of that college for yourselves.

PRESIDENT: Are there any others that would like to have something to say? I am glad most of you feel as I do. I thought, perhaps, some of you had something to defend, I have nothing, and I have nothing to say. Will Dr. Flexner make some remarks in closing?

DR. FLEXNER: No, thank you, Dr. Babcock.

PRESIDENT: We will now have a paper that does not appear on the programme. The Surgeon General of the Marine Hospital appointed Dr. Austin as a delegate, and at my request asked Dr. Austin to prepare a paper for the Association. For some reason or other the request was late in coming in, and Dr. Austin had a very short time in which to prepare his paper. I will ask Dr. Austin to come forward.

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## GENERAL HOSPITALS IN PREVENTIVE MEDICINE.

BY SURGEON H. W. AUSTIN,

*U. S. Public Health and Marine Hospital Service.*

The primary purpose of the general hospital is to afford better care for those who are ill than they can obtain in their homes and for those who have no means for providing proper care for themselves. But there is another purpose for the hospital—it serves to prevent the further spread of diseases by removing the sick from their homes where they cannot be as well cared for, thereby protecting their families and the public as well. Hospitals as public institutions should, so far as possible, be organized, appointed and conducted to meet these requirements, and furthermore, for the purpose of advancing our knowledge in State medicine.

Some of the larger general hospitals have now well-appointed and equipped pathological chemical, bacteriological, clinical and physiological laboratories. These, together with the complete clinical records, which should show the antecedents so far as possible of each case admitted, furnish a fund of information that cannot easily be obtained elsewhere. The possibilities for useful work in the large hospitals as auxiliary to the health authorities in conserving the public health is, I believe, much larger than now obtains. The organization and appointment of hospitals should be made with the view of furnishing information to municipal, state and national health authorities that would be of service to them in their work of conserving the public health, and health officers should be in close touch with the hospital authorities.

Cases of infectious and contagious diseases admitted to hospitals are now required to be reported to the health authorities, but there is much information that can be obtained at a large general hospital besides the report of

admission of contagious diseases, that would be of service to the health authorities of a city. For example, cases admitted to hospital showing an unusual prevalence of diarrhoeal diseases, pneumonia, and diseases due to crowding or starvation in certain districts, tenements or apartments with the laboratory examination records.

It is important in public health work, that a full history of each case be recorded, giving the location of patient's home, his vocation, whether others have been ill at his house or in the neighborhood, and many other inquiries which the character of the disease might suggest to the admitting officer. There are at present under treatment at the U. S. Marine Hospital, New York, ten cases of enteric fever, three of which were taken from one steamship, a large trans-Atlantic liner, about the same time. A case had also developed upon this vessel among the crew a few months before and died at the hospital. I recommended an investigation as to the cause and an immediate emptying and disinfection of the water tanks and disinfection of the forecabin.

The first cases in an epidemic disease are frequently discovered in a hospital. This is perhaps more frequent in the U. S. Marine Hospitals than in any other class especially in exotic diseases. The reason of this lies in the vocation of the patients admitted. The sailor frequently visits foreign ports where they are exposed to tropical or other contagious diseases; their freedom from restraint in such ports and the conditions surrounding the life of seamen which is one of exposure and hardship.

As an illustration I quote the following from my report of the hospital at San Francisco made to the Surgeon-General in 1909:—

"The relation of this hospital to the public health of San Francisco and other cities on this coast is most intimate. In a great seaport city like San Francisco where vessels ar-



rive often from nearly every country in the world unusual diseases are likely to be first seen among the officers and crews of vessels of the merchant marine, the army transport vessels, and the United States Revenue cutters. If they are sick upon arrival, or are taken sick some time after, they apply to the hospital for relief.

"The first two cases of plague in San Francisco which were recognized and reported were patients in the United States Marine Hospital. Immediate investigation of the antecedents of these patients was made from the hospital and reported to the United States Quarantine Station and to the city health authorities, when the Board of Health disinfected the places where the patients took their meals and other places in the city which it was found they had frequented. They also commenced the destruction of rats in the neighborhood of these places and found many that were infected. The active co-operation of the medical officers at this hospital at the request of the city authorities in the preventive measures taken at the commencement of the outbreak of plague before the Government assumed control of these measures, is in part a matter of official record.

"In the erection of the new permanent buildings at this station, I have to recommend that a separate laboratory building be built for hospital and public health work. A large, well-equipped laboratory is needed here, and I know of no better field in the United States for the study of certain tropical diseases, than can be found in connection with this hospital."

The affiliation of the large hospitals of the country for improvement in hospital management and methods, in hospital organization, in hospital buildings, in hospital equipment, in hospital reports, in recording the histories of patients, and in hospital sanitation in general is of inestimable benefit.

In the interest of the public health, the co-operation of the affiliated hospitals with the public health service of the nation would be of great value.

It would be most useful to the Public Health and Marine Hospital Service to be able to obtain early reports from hospitals of the unusual prevalence of any disease in a given locality, of any investigation made by the hospital regarding the same or other information affecting the public health which can be gained at the hospitals.

Again, there is certain information which the Bureau of the Service in Washington can furnish the hospitals that would be useful to the hospital authorities.

Just how such co-operation in public health work could be effected I am not prepared to state, but I believe there is a great field for public health work in many of the large hospitals which is not utilized, and that some sort of affiliation between the hospitals and the Public Health and Marine Hospital Service would be of mutual benefit.

The function of hospitals in the study of preventive medicine was recognized by the last U. S. Congress in the opening of U. S. Marine Hospitals for special investigations of the cause and prevention of contagious diseases, and during the past summer an investigation as to the cause of pelagra has been conducted by an expert officer of the Service at the U. S. Marine Hospital at Savannah, Ga. A similar investigation which is now being conducted at the U. S. Marine Hospital at Wilmington, North Carolina, of problems concerned in prevention of hookworm disease. Furthermore, an important discovery has only recently been made in the mode of transmission of measles at the Government Hospital at Ellis Island by medical officers of the Service.

There is ample opportunity for research work in many of the large general hospitals and, where funds from the State, from corporations or from private sources for such work can be obtained, the appointment and equipment of these hospitals should be made with the view of doing research work and of advancing our knowledge of preventive medicine.

Adjourned till 8 o'clock p.m.

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## ROUND TABLE CONFERENCE FOR SUPERINTENDENTS OF SMALL HOSPITALS.

MISS MARY L. KEITH, *Chairman.*

THURSDAY, SEPTEMBER 22—8 P. M.

## ADMINISTRATIVE.

Topic No. 1.—*In a hospital of one hundred beds, which brings better results, having the hospital and training school under one head, or under separate heads?*

CHAIRMAN: Our associate chairman has had experience in both methods, and I think it is proper that she should start the discussion on this question. Miss Cadmus, will you tell us the results of your experience in both methods?

MISS CADMUS: I would unhesitatingly speak for the two heads, for the superintendent of the hospital and the superintendent of the training school. The training school, in order to be successfully carried on in a hospital of one hundred beds or more, must have a head of the department whose time is given solely and undividedly to that work. I do not believe it is possible for any one person to administer to the affairs of the hospital and training school and do it well and be just to all concerned.

MR. SOUDER: I can speak of a hospital of forty-five beds where we tried both. About a year and a half ago our superintendent was director of nurses and also matron, but the Board of Trustees found that she could not give the proper attention to the training of the nurses, the enforcing of discipline and order in the house; so they made a change and simply had the office of superintendent made one, and director of nurses and matron combined. For the last year that has been working very successfully.

MISS ANDERSON: Theoretically, perhaps, the assistant should be superintendent of the training school, but the assistant must be practically as good a woman as the one at the head, as she so often has to take the place of the superintendent. It is not easy to get such a woman unless she regards the position as a stepping-stone to a head position in another hospital. That means frequent changes. So I have found it more satisfactory to consider my assistant purely as an assistant, and, although her duties are largely those of a superintendent of nurses, I prefer her to be entitled "assistant superintendent."

MISS STOLZ: We have a small hospital of thirty-nine beds, and we would not think of having our training school and hospital under one head. We also have a separate matron. I think it is quite out of the question for one person to undertake so much.

MISS BRENT: My experience has been the same as Miss Anderson's. As superintendent of the hospital I have entire charge of all and my assistant is called assistant superintendent, in view of the fact that the house staff are under our control, and they do not take kindly to administration of discipline from the superintendent of nurses.

THE CHAIRMAN: My own experience is similar to that of Miss Brent's. In the hospital in which I have the good fortune to be placed, the hospital and the training school are under one head. I have an assistant who is the assistant superintendent both in the hospital and in the training school. We have a second assistant superintendent who is an executive assistant and whose headquarters are in the office. She is one of the graduates of our own training school and is an expert bookkeeper. She has charge of collections and she has an assistant bookkeeper and still another office assistant. On the training school side we have a training school assistant whose duties are confined entirely to the training school. The assistant superintendent is responsible for the care of patients and that puts her practically at the head of the training school, and on questions of policy, discipline or instruction, we always confer. The training school assistant is really an assistant to the assistant superintendent, whereas the executive assistant is more my assistant, and contrary to some of the experiences stated this evening we find that our plan has worked very well. We have a training school of sixty or more pupils. Our hospital has the capacity at the present time of one hundred and fifty beds, which we are increasing very materially for the coming year. We have a probationer instructor, and we have a resident instructor for the theoretical work, but it is all under the authority of the superintendent.

MISS CADMUS: I do not want to be understood as advocating making the training school an individual department. The superintendent of nurses, I think, in all cases, should be the subordinate officer of the superintendent of the hospital. Generally speaking, it seems to me any one can do his or her best when they have full responsibility and women can do their best work in a training school where they feel that they have to work out their own problems, but that does not mean that they are not to confer with the

superintendent or that they are ever to be in a position where they are not in the closest and most harmonious touch with the superintendent.

MISS LURKINS: When the superintendent is absent and the superintendent of nurses is also matron, who looks after the matron's duties when the superintendent of nurses is doing the superintendent's work?

MISS VAN VORT: (Richmond) With us the superintendent of nurses takes the place of the superintendent, and the night supervisor takes the place of the superintendent of nurses, and then we put one of our head nurses in as night supervisor.

No. 2.—*How the work of the small hospital business office can be arranged so that the superintendent may occasionally leave the hospital in the evening.*

MISS KRAEMER: We have a night chief who takes the place of the superintendent at seven o'clock in the evening, which makes it possible for the superintendent to go out every evening if she wants to; but I think in that question the words "in the evening" ought to have been left out. I think the superintendent has a right occasionally to go out during the day; there ought to be somebody to take her place then. We have it so arranged that we can go out, the director of nurses and superintendent taking turns, exactly as the nurses do, unless there are emergencies. We are surely entitled to that. I think we have all gone through the experience of working until three o'clock in the morning, doing the bookkeeping at night and getting up at six o'clock in the morning, but I think that stage is past and no woman who takes charge of a hospital has any right to work such long hours, it means a broken down system.

THE CHAIRMAN: Miss Kraemer, is your night superintendent given power to admit patients, to send out the ambulance, to open a new ward and to make any arrangement which you would make if you were there?

MISS KRAEMER: Yes, absolutely.

THE CHAIRMAN: I congratulate you on your night superintendent.

MISS GATHON: I should like to know what we shall do when there is no night superintendent.

MISS KRAEMER: I should insist on having one.

THE CHAIRMAN: The report on training school curriculum, gotten out by the American Hospital Association some two years ago, stated very emphatically that training schools should have a graduate nurse night superintendent, and we went on record as disap-



proving of patients being left at night without trained or competent supervision, and I think that is a point which might very properly be brought home to the directors, the trustees, and the managers of a hospital as to whether that is a recommendation which could be overlooked or ignored. There are a great many of us who agree most heartily with Miss Kraemer that an assistant is a necessity if the superintendent is to continue a life of usefulness and if she is doing good work, it is, of course, very much to be desired that her life of usefulness should be prolonged to its greatest possible extent.

### NO. 3.—*Supervision of Internes.*

DR. PRATT: It seems to me there should not be very much question but what the superintendent would be the only one to have charge of that matter as he is responsible for the work in the hospital, and of all the employees connected with it, and as this is relating to the internal management of the hospital, it seems to me that he is the only one, or she, in case it is a lady superintendent, who should have anything to say in that matter.

MISS BRENT: The house staff are entirely under the control of the superintendent. I practically have the appointment of them. The list is sent in from the medical schools and the secretary re-opinion of them. We ask for no letters from the physician. I then make investigation privately as to the standing of these men in their classes and also their personnel, because, unfortunately, the gold medalist is not always the most suitable man to carry on the work of the hospital. The list is then made out and I send in to the trustees the names in their order that I think would be well for them to accept, and it usually is adopted. Occasionally we have to make a little change. When I see them, I ask them if they have any objection to being under the control of a woman, and if they have, not to come in, because they are going to be under the control of a woman. In most cases we get on nicely; we have very little friction over matters of discipline. If I see in the course of their work that they are not doing their medical work as I think they should, or making a prescription that I think should not be given, I have a right to withhold the prescription until I have communicated with the staff under whose service they are working. I have a book of rules, if any one cares to see it afterwards. I have refused to sign a diploma, and I have requested the resignation of two men since I have been there.

THE CHAIRMAN: May we know how many internes your hospital has?

MISS BRENT: We have five; two men come in for eighteen months' service and three for one year's service. The men come in every three months. We get a new man and a senior house officer. They serve in terms of three months with the exception of the pathologist; he is there for six months.

DR. MUSSELL: I am a medical directors and superintendent of a hospital with eighty beds, and it would seem to me that if a superintendent is to have authority over the internes it would be necessary for that superintendent to have some years of experience. In the case where the superintendent happens to be a young woman with little experience in management and in the medicines that were necessary for patients, some one with medical education should have authority over the internes.

THE CHAIRMAN: In reply to the last speaker, I did not understand that this matter of control extended to matters medical or surgical, the question is one of order, internal management and discipline. I think no one took it other than that the medical and surgical staff control the internes in matters medical and surgical.

DR. KAVANAGH: My superintendent is the responsible party; that is, the house staff is responsible to him for everything except the medical and surgical care of his patients and they are responsible to the superintendent for the fact that they care for them. As to the prescriptions that go down through the supervisor's office, we have a rule that each prescription must be read aloud by the nurse after the doctor has written it, which sometimes is quite a puzzle; but before they get through she is able to read the prescription and is satisfied that it is all right; then it comes down to the supervisor's office. Once in a while it is held up there. If it is not held up there, it will be held up by the pharmacist, a man we have had with us about twenty years. I think we can say he has never made a mistake; that is what my physicians tell me, so that it has to run the gauntlet of quite a few responsible parties before the medicine comes to the patient. I have suspended internes and will hold them up, as I have from time to time held them up, but it is very seldom necessary to do that sort of thing.

DR. BRUCE SMITH: I think no matter how young the lady superintendent is, she is able to exercise control over the interne if the interne is at all fit to be appointed to that position. A few weeks ago I was asking a lady superintendent—I do not see her here tonight—"How do you manage your internes under this head of discipline, how do you prevent their flirting with your nurses?" She said, "I take every interne into the office when he comes on duty, I show him my hand, and I tell him that there is the only hand that is allowed to be held here."

DR. E. B. SMITH: I think there is no question but that, no matter if it does happen to be a lady superintendent, she ought to reign supreme. Our board of trustees back our superintendent in everything that she does. This superintendent is not the superintendent of nurses, she is superintendent of the hospital, but she gets every one of the nurses to come to her room and she tells them that she is the mother, and she gets them to confide in her. These internes know that she will not interfere with them medically or surgically in their work, but she does interfere if they do things that she does not approve of. She lays down the rule that an interne must not take out one of the nurses without her permission or without the permission of the superintendent of nurses, and just the minute that he violates that law, then there is trouble. She does not have to go to the board of trustees; she does the business herself.

MR. BORDEN: One of the advantages of a small hospital is that we always have womanly women in charge of the institution, and there is no one that will have more authority over those young men and will do more for the protection of the nurses and for the best interests of the young men themselves than the womanly woman who presides over that institution, and she should have full authority to manage in every way the internes under her control.

THE CHAIRMAN: I think most of us will agree with the last speaker, and if there is nothing further, we will take up the next topic.

No. 4.—*The wisdom of allowing patients' friends to spend the night in the hospital because the patient is nervous or objects to being left alone.*

THE CHAIRMAN: We take it for granted that the patient dangerously ill should have the presence of friends or the nearest kin, the question, as I understand it, is whether, when the patient is lonely and desires company, it is wise to have the friends remain or otherwise.

MISS WASHBURN: I am not aware of its being customary to any extent for the friends of patients to remain for the reasons given here where the patient is nervous. As the Chairman says, when he is dangerously ill, of course it is our duty to have the friends near, available, if not in the hospital, at least where they can be readily notified. In the case of a nervous patient, that is, the neurasthenic patient who comes to the hospital for treatment of that particular trouble, because the question of his rest is one of the most important ones, the question of his having visitors, whom he shall

have and how long, etc., is a very important part of the treatment and is arranged by the physician in charge. Occasionally, exceptions are made, but I can hardly state whether it is wise or not in cases of certain exceptions. With children it sometimes seems desirable for parent or relative to remain, and in our children's wards we have some rooms arranged in that way.

THE CHAIRMAN: In the event of your being willing that a member of the family should remain, would you provide a couch for comfort, or draw forth a chair?

MISS WASHBURN: We are not able to provide a couch, we simply give them chair space. Sometimes they remain at the office.

MISS LIGHTBOURN: If there is a vacant room in the hospital and the friends choose to take it at the rate we charge a patient and we do not need the room, they may have it. That often discourages them from staying. With children we do permit one parent or relative always; in that case we provide a cot, charging extra, but we do not allow them to stay just from mere fancy. We charge the regular rates for meals.

DR. MORRILL: Every time I have allowed a parent or relative or even a friend to remain at the hospital over night, the child has been the worse for it. I also know that in cases of contagious diseases, if I can take the child out of the house and into the ambulance, as I do in certain cases, simply walk to the ambulance and get away, the child is better off, it will go to sleep till the ambulance is up to the hospital. But if the mother or father or anybody they know goes with it, it will cry and cry itself to sleep. I do not allow any visiting inside the hospital, the visiting is all through the windows. At a rough guess, I should say fifteen per cent. of the visitors, learn that themselves from their own observation without being told. An adult who is so nervous as to require some one to stay with him, I think, is in the same frame of mind as a child and should be treated in the same way.

DR. GRAHAM: It seems to me that this question belongs to the same category as a request to go into the operating room. I am at present in a hospital field in which great latitude has been given visitors and it is a condition that I have not had much experience with, but it seems to me that the main thing is the care of the patient, is it best for the patient or is it not? I think every one who has had any experience with the treatment of children's diseases, even of a non-contagious character, can agree heartily with the last speaker. If we should ever forget the calendar day, we could tell that it was visiting day by the noise that came from the

children's ward at the visiting hour. I think that all of us are ready to say that visiting is harmful to the other children. I think the first question that ought to be asked of persons who desire to stay with a patient, "Are they trained nurses?" and if they are not, I do not think they should be allowed to stay unless the patient is in distress, whether in a public ward or a private room. I am speaking feelingly, because I am having a great deal of trouble, because the practice has been to allow everybody to stay with the patient. I have absolutely set my face against visiting in the operating room and yet the practice has been to have a very social sort of visit in the operating room with the patients while they are being operated on.

MISS ANDERSON: My experience has been the reverse of that of the speakers. I have never refused patients' friends a cot if they required one. If the patient was nervous, I found it helped the patient, especially before an operation. I do not know of anything that would tend to take away the terror that most people have of hospitals than this one thing. They dread to leave their home and their family, and if we can make the hospital into a home, then I think we have done a great benefit to the medical profession, because while we cannot turn a home into a hospital, we can turn a hospital into a home. I think I have made more friends for my hospital in that way than in any other way.

DR. TRUESDALE: I have had the problem of allowing the relatives of patients in an operating room and after having a few embarrassing experiences, I came to the conclusion that a little tact ought to be used upon the relatives, and I now ask the relatives to hire a special nurse to look after them while they are in the operating room.

No. 6.—*Admitting delirium tremens cases to the ward with other patients.*

MISS SIMPSON: It does not seem as if this matter could really have two sides. It is a question that all city hospitals and all general hospitals, I believe, have to deal with, and so far as I understand, very few hospitals have special wards for alcoholic patients. We are always getting delirium tremens patients, some come to us alarmed at the approaching demon, some are brought by nervous relatives, and many are brought to us by the very cautious police who are afraid to lock them up, and we have to take care of them. We have no adequate way of isolating them, no special ward for them, we are obliged to put them with the other medical patients. It seems to me that it is the wrong



thing to do; it is very difficult to make nurses and attendants, and I might say even doctors, consider delirium tremens cases with the same sympathetic feeling with which they consider other patients. It seems to me wrong from the point of view of the patients who are legitimately sick. The patient disturbs the wards, of course; so I cannot see, from my point of view, how there can be any talk of the necessity of keeping them in separate wards. We are hoping that the time will come when the state or city will have proper institutions for inebriates. A public ward, in my mind, is not the place for delirium tremens cases and for treating people who are alcoholic.

THE CHAIRMAN: This is a very real problem to many of us. In New York State there is a special law which specifies that your ambulance, having answered the call, must bring the party to the hospital, and in that way the ambulances bring in a great many cases which are verging on delirium. The smaller cities have no municipal hospital and the private hospital which has answered the call has the case of delirium tremens on its hands. It was in answer to different questions of this kind that this question was brought before the meeting to-night. As I understand it, most of us have had them deposited at our doors, we have no wards to put them by themselves, there is no municipal hospital to take them off our hands, they are too sick to be left at the police station; what are we going to do with them?

DR. PRATT: We find it very frequently necessary to take them to their homes, and there insist that their relatives have some one to watch them and to have some physician attend them. That seems to be the only possible way to do when they cannot be taken to the hospital.

MR. SOUDER: If we are called up to take in a delirium tremens case we find out whether the patient has a physician, and, if so, we compel the physician to call up the hospital. We will not admit that case unless it be as a private patient in a private ward. If brought to our doors and left there, we have to take them in. We have had cases where the patrol wagon brings in violent cases, which sometimes take two internes to hold them down. It is dangerous for the nurse, because, unless they are strapped to the bed, they are apt, as they often do, to strike a nurse. We will not admit them into our public ward outside of the accident ward. If we have no bed in the accident ward, we will put a cot in there. There is hardly a week that somebody is not brought in bordering on delirium tremens by the police, who do not want to take them to the patrol stations. That is one of the questions that our hospital has a great deal of trouble with. When the ambulance brings in



cases of people who are amply able to pay, whom the doctors want to get off their hands, we will not take those cases, except in a private room under their own physician and trained nurse.

No. 7.—*Should the hospital bookkeeper be expected to do her work in the general office?*

MISS BEATTY: Our bookkeeper has a separate office and our bookkeeping is done there. We have a financial manager who is assistant to the treasurer. I admit the patients in my office and then the financial arrangements are made in the bookkeeper's office, she receives all the money. This financial manager spends half the day in planning the business of the office and he has an assistant who attends to all the details. This arrangement has been in force the last three months. Previous to that time we had a bookkeeper who attended to the telephone and assisted the medical directors, but we found there was too much detail imposed on her; so our Finance Committee decided she had more than she ought to do and they relieved her of some of her duties. She makes a statement from time to time as requested.

MISS LIGHTBOURN: Our bookkeeper has an office just off the general office. I think it would be impossible for her to be expected to do the work at the switchboard and answer the constant demands on the clerk at the window. She is just beyond the general office. The clerk at the window sees to the receipts. The bookkeeper goes through the accounts of people who are delinquent, but does not attend to the work that comes to the general office.

MISS COSNER: What can we do when there is only one office and every one comes in there?

THE CHAIRMAN: It can be done, we know. We do it in our hospital; you and I seem to be the only ones who have it done that way.

MISS CADMUS: Here is another.

DR. CLOVER: Our bookkeeping is done by the cashier and the assistant. The cashier has a separate office, we have always had a man, but we have a most efficient woman just now, the most efficient cashier I have had. She keeps all the financial books and makes all the collections, makes up the statements for the superintendent and for the board of managers. Cash receipts and disbursements are made by the cashier and the checks are endorsed by the superintendent of the hospital after the bills are O.K'd by the heads of the various departments that have received goods.

THE CHAIRMAN: While our hospital was considerably smaller than it is at present, we had one woman in the office for the general office work; she was a graduate nurse of the hospital and she had been taught bookkeeping. She directed people to the proper departments, answered the telephone and kept the books. She did that for a good many years, and as the hospital grew she was given an assistant to do simple clerical work, who put the slips up on the board, helped with the telephoning, and so forth. My second assistant is an unusually capable competent woman; it might not work equally as well in other places with other people, but when the work became too much for the two, we made the third appointment, that of assistant bookkeeper, and our bookkeeping is still done in the midst of the general office and in the midst of a great deal of other business, and it is well and accurately done.

No. 8.—*Should the small hospital charge for the board of graduate special nurses?*

THE CHAIRMAN: We know in the large hospitals where a great many outside nurses come in as specials, that the board is a considerable item, and I think the custom is universal of making a charge for board for nurses in the larger hospitals. In the smaller hospitals, where the number is limited, the question is asked is it customary.

MISS BEATTY: We charge \$5.00 a week for the board of special nurses. The nurse sleeps at the hospital and has some six hours relief. We have sometimes five or six special nurses on duty at the same time.

MISS SHARP: I should like to know why the small hospitals should not charge.

THE CHAIRMAN: I do not know that there is any reason why they should not. A good many smaller hospitals do their own special nursing and unless there is an unusually large number of patients there might not be more than one or two outside special nurses. It is only a question of whether it works out better to make the charge or not. For a long time we made no charge for board.

DR. MORRILL: When the nurse goes out to private families she receives wages and board. The minute the hospital begins to compete with the trained nurse in the home by cutting out the board, we are mixing up in something that might or might not cause trouble, in other words, we ought not to do anything which will cut down the standard of payment for the trained nurse.

MISS SHARP: I never understood that the board of the nurse came out of her salary. My understanding is that it came from the patient's pocket, the nurse's salary is not reduced from the charge for board.

THE CHAIRMAN: I think the question is whether the patient should pay for the board of the nurse in the hospital. In this connection a question has been handed in: "Are practical nurses without hospital training allowed to do special duty in the hospital?" Is there any one here who will tell us either that they allow it or that they do not allow it?

MISS OAKES: I do not think they could possibly be permitted to mix with pupil nurses, because it would be a very bad example, demanding three years training from every good woman and then admitting a practical nurse on the same basis to receive the same same compensation with them.

DR. MORRILL: As a matter of fact, I think there should be no question from the business standpoint with reference to the charge for the board of the special nurse. Furthermore, I do not think, in a case of that kind, that the hospital is under any obligation to supply any one in the interim when this nurse has her hours off. If a patient in the hospital needs a special nurse, he should supply two nurses, if he is sick enough to require constant attention. Where the hospital supplies a nurse for six hours and they receive no compensation for that, it is robbing some other nurse of a fee that she is justly entitled to. In other words, the patient should have two nurses. In our hospital we charge one dollar a day. We only give the floor duty to that patient when the nurse is resting, and we request them to get the second nurse. It would be poor business policy not to charge for this. I believe in holding up the hands of the trained nurse, and we do insist in our places that two nurses be hired, and we do not take the time of our floor nurses from their own duty.

MISS McCALMONT: Does not the hospital owe a private patient something in the way of nursing when they pay for a private room, which might be in the relief of a private nurse? It seems to me that that is really included in the price of the room which they are paying for.

DR. CLOVER: I feel very strongly that a hospital owes, morally and legally, a private patient care. Frequently a private patient comes to an institution, takes a room, not very ill, and does not foresee the expense of a special nurse; the patient becomes very ill, you find that the relatives and friends cannot afford to pay

for that nurse. The burden, I think, rests upon the hospital. They have to take care of that patient, even though special nursing cannot be given, and if we accept that as a fact, then the hospital must supply that nursing from the school of nurses. I think it is very clearly an obligation and duty that the hospital cannot get away from. We have at St. Luke's a rather large private patient pavilion. We have seen the problems of caring for private patients from all these points, and I feel that at St. Luke's, when we once take a private patient we must see that that private patient has complete and adequate nursing.

DR. MORRILL: I think the last speaker misunderstood. I was talking to the question not of the responsibility of the hospital in taking care of its patients, but the question of whether the hospital should charge for the board of a special nurse. There can be no difference of opinion as to the hospital's responsibility in the matter.

A MEMBER: Is it customary, if there are two graduate nurses alternating, to charge board for each one?

THE CHAIRMAN: That brings up the question of whether special nursing is twelve hours or twenty-four hours. In at least one hospital that I know of board would be charged for each nurse, not at the rate of one dollar a day, but perhaps one-half of that amount for the meals which the nurse had, and in this particular hospital, the nurse does not sleep at the hospital, she sleeps at her own room and comes in either for day or for night duty, and the charge is made only for the board of the nurse. This same hospital offers nursing care to the patient, the price is so many dollars per week with the service of the floor nurse, that means the patient will be taken care of; it does not mean that the nurse will stay at the bedside all day and night. If the family or patient desires constant attendance, there would be a special nurse and a special charge would be made. I do not know of any hospital that refuses to furnish adequate nursing care, but a great many are not able to furnish company for every moment.

No. 9.—*Wanted—a satisfactory set of rules to control visiting in the maternity wards and private rooms.*

THE CHAIRMAN: I interpret that to mean maternity private rooms. We know how many dangers accompany visitors in the maternity department, how susceptible the new mother is to infection, we know how inconvenient visiting often is on account of other cases which may be in labor in adjoining rooms, and yet on

the other side we know that the wife desires her husband, and it is right that he should be there, that if there are other children she wants to be assured that the children are well and there is always the new baby to be inspected and admired, and it is a great deal of a problem how to take the middle course or take any course that is satisfactory. I should like to hear from Miss Cadmus, who is in charge of a maternity hospital.

MISS CADMUS: We have no visiting in the wards, absolutely none, excepting in cases where the patient is very ill, then the nearest relatives are allowed to see the patient. In case of the waiting women, they are allowed to go down stairs to the admission room, and meet their friends there. We do everything in our power to make the people as comfortable as possible by allowing them to come into our waiting room and write notes to their friends that are taken upstairs and the answer brought back. We also do everything in our power to tell them about the patient and about the baby, how it looks and everything that we think they would like to know. In case of dangerous illness, we assure the friends that if there is anything to be apprehended, that they will be allowed to see the patient. One of the reasons why this very strict rule is made, aside from the one mentioned by Miss Keith is the nursery. We could no more keep the visitors out of the nursery than we could fly without the aid of a flying machine. It would be perfectly impossible, and that is one reason why we cannot permit any visiting on the ward floor. In private rooms, for the first week, we limit the visiting to the very immediate family, the husband, the mother and the sister, at least very few. After the first week, we allow four visitors a day, unless the patient is unusually strong and well, and we never allow more than two at a time. I think you will be astonished to see how readily people accept all this; the Italians and the Poles, people that do not understand English, accept it very readily, and I think they take a great deal of pride in that they do understand that we have a scientific reason for not allowing general visiting in our wards. We really have very little trouble.

MISS JOHNSTON: We have the same rules governing all our private patients and our ward patients, except the visiting hours in our wards are very short compared with private rooms. For the first eight days we exclude all visitors, except husband and mother. If a person has not a mother, she may have one other person whom she chooses to take the place of mother. We find a great deal of difficulty in keeping even this rule. I should like to ask Miss Cadmus how they control two visitors in the room at one time? We find it hard when they first know the way to the patient's room.

MISS CADMUS: Our office is at the front door, they cannot pass us.

DR. KAVANAGH: We have practically the same rules aside from the nursing, for the ward work and private work. We allow one visitor a day to the wards by card, some member of the family. When a patient enters the hospital, we give them a family visiting card that can be used each day, may be passed from one member of the family to the other. That is the system in the maternity department, and I have never heard of any complaints. The nurse that has charge of that work is here to-night, Miss Phillips; she might say something about it that I do not know.

MISS PHILLIPS: I do not allow anybody to come up to see the mother till the third day. I allow them to come in and see the baby, if they come to the desk and ask me. I never have any trouble, nobody comes into the baby room without asking the nurse or without asking me. We allow no one in the labor room except the doctor and nurse.

NO. 10.—*Wanted—a formula for securing loyalty from heads of departments.*

DR. MORRILL: If the head superintendent is disloyal to the department heads, he can expect but disloyalty from them; if he is loyal to them, he can expect nothing but loyalty. If you undertake to run your place with military discipline, you must expect your subordinates to try all the military dodges. You cannot expect any more than you give. Those are generalities, but, to be specific, if you go to a ward and give your orders direct to a nurse of that ward, ignoring the head nurse, the head nurse will immediately look out for herself, and you started it.

DR. BRUCE SMITH: The hospital is a public trust; the superintendent is a trustee and responsible for the appointment of the persons who occupy the positions as heads of departments. The superintendent should never have a subordinate appointed without his or her consent. In my experience I have found where disloyalty creeps into a staff, it is very largely not the superintendent's fault, but the fault of some one who, by some influence or other, has secured the appointment of some one who was unsuitable to the particular branch of the service. Avoid that and you will avoid that disloyalty which is so inimical to the interest and prosperity of the public trust, the hospital.

DR. SHARP: If we study the organization of the department stores and such companies, as for example, the Standard Oil, you will find that the principle that they employ is gathering together



the heads of their departments; they talk over their difficulties and they plan out a campaign which is going to improve their business and improve their personal position. Might we not in a hospital, however small, or however great, adopt that principle and have a consultation of the heads of departments and let them understand that they are a factor in working out the best interests of the institution?

MR. SOUDER: I think the most effective way to secure loyalty from heads of departments is to make them feel that you are their friend, let them understand that you expect from them the same as you give, let them feel that you are setting an example and that you do not ask them to do any more, perhaps not as much as you do yourself. Let them feel that they can come to you for anything and find a sympathetic friend.

#### TRAINING SCHOOLS.

No. 1.—*Providing applicants are of equal intelligence, whether it is better to employ graduates of one's own school for official positions, or graduates of other schools.*

No. 2.—(a) *Which is preferable, a graduate head nurse or a third year pupil in charge?* (b) *Is the third year pupil in charge able to assume necessary responsibility?* (c) *Which is more loyal, the graduate head nurse or the third year pupil in charge?*

MISS AIKENS: In regard to the first question, if I had been asked that question a number of years ago, I should have said without hesitation that preference should be given to our own graduates every time, but a few years' experience teaches us quite a few things, and I am sure it is not a question that can be answered by yes or no. The question of the head nurse is entirely one of intelligence, in the first place, I believe the disposition of the individual has greatly to do with it. I think we are all rather prone to get into ruts and follow the course of least resistance. We all appreciate the comfort it is to have a nurse that has our way of doing things in the institution, and can get along without so much breaking in as a new head nurse from another school, and yet I am very sure it is not a good thing for hospitals generally to settle down to the idea that the head nurses should be their own graduates entirely. I think that where there are several head nurses to employ a mixture is a pretty good thing, and I believe

on the whole that it is a pretty good thing before putting a graduate nurse in an executive position in the hospital where she was trained, to put her somewhere else for about six months, to get her rid of a lot of little petty prejudices that she is apt to have, and she will come back to us broader and better than she would be upon stepping into a position immediately after graduating. The question of graduate nurse or a third-year pupil in charge is another question that I do not believe a fixed answer can be given to. My own preference in every case would be to have a trained head nurse at the head of the department rather than a pupil nurse, because I believe our head nurses are being depended on more and more for teaching, and I believe we turn out better trained nurses if we have permanent head nurses in charge of our wards. The pupil nurse lacks accumulated experience, and it is a question whether there is half as much economy in it as we are inclined to think, because a pupil nurse certainly cannot enforce discipline and economy with the same authority that a graduate nurse can. As to the latter part of the question (c) I think that it is a great deal a question of the individual.

MISS AYRES: In my experience with the graduate and pupil head nurses would consider from the hospital standpoint but two advantages in having pupil head nurses. First, one of economy, that in saving the salary of the graduate; second, the opportunity of testing the administrative resources of your school for future reference in securing suitable graduates to fill vacancies that occur in the executive positions. The disadvantages, frequent change, for six months is nearly the maximum portion of a pupil's senior year that should be spent in one ward, perhaps some pupil has exhibited marked administrative talent, and you compromise by giving her a second ward or a surgical following a medical, or vice versa, that her practical experience may not suffer. From the standpoint of the pupil the opportunity to take charge of a ward is most valuable. Nothing so develops a young woman as responsibility. She may not enjoy it, may, in fact, lament that it came to her; but rarely do you question a nurse on graduation as to the value of the term of training that her testimony will not be that she derived the most from the months she was in charge of a ward or some department. I am sure we can all testify to the surprising development of some considered negative material under the pressure of administrative responsibility. She appreciates more than ever before the trials of her superior, when she herself is made responsible for the work of her assistant nurses to meet the needs of the hospital. I think every training school superintendent will agree with me when I say that the pupil head nurse has just gotten to be of value when you must change for another. The

graduate head nurse has more authority with the pupil assistant in her ward, with the house staff, and the visiting staff appreciate the permanent head who knows the routine methods. The graduate head nurse can give her entire attention to her ward, classes, lecturer and examination are not absorbing her off duty time. She can devote more time to rest and recreation. Undoubtedly the graduate has better judgment in the ordinary and use of hospital supplies than the average pupil head nurse. Hence the question of doubtful economy for the hospital. I think the third year pupil, if selected from the more promising members of the class, can be made to take the responsibility with plenty of aid and counsel from the officers of the school, but I shall always feel that the pupil derives more benefit from the system than the hospital. Loyalty is a quality that belongs to the individual, and may be present or lacking in both the pupil or graduate head nurse.

No. 3.—(a) *Methods which have proved successful in dealing with destructive and wasteful nurses.* (b) *Should pupil nurses pay for articles broken or destroyed?*

DR. HOWELL: I should say it is very much to the nurse's advantage if she simply pays for the things that she breaks. It teaches her the cost of things. When she once knows the cost she is much more apt to be careful than if she can use any amount she wants.

THE CHAIRMAN: I think there are a great many of us that agree with Dr. Howell, that it is the surest way of teaching nurses, even though it is hard at the time.

No. 4.—*Need of a system for keeping a record of practical work done by pupil nurses in the wards.*

THE CHAIRMAN: That has reference to a condition which all of us experience sooner or later, that a nurse well along in school, nearly ready for graduation, who, on being asked to give a hot air bath, or something of that nature, says she has never done it, or that she has not done it since her probation period; when about to graduate, announces that she has missed an opportunity to practice certain instruction that was given her early in her training. That I judge to be the purport of this question. Is there any one here who has a method of keeping track of the work which the nurses do in the ward?

MISS LIGHTBOURN: In our school, we keep track of everything she tries to do, and we try to provide time to have it include everything that she may be called upon to do, and in that way keep one record as to what she has been shown and taught how to do. This record is kept on a card first and then copied into a book.

Nos. 5 and 6.—*Who has a successful method of disciplining pupils? The social side of training school life.*

MISS CADMUS: I think the personal equation of the one who is in charge is really the keynote of it all. Perhaps I will modify that a little. Of course, what the superintendent is able to attain in her organization counts for a great deal, but in dealing with a body of young women in the relation of the pupil nurse to the superintendent it seems to me that you cannot eliminate the personal factor, you have to count it about nine-tenths. I cannot see how you can lay down any hard and fast rule for discipline. It is something that is too delicate and indefinite until you come to it, and then your tact, judgment, humaneness, kindness, knowledge and all the qualities that go to make up a successful superintendent must be called into play.

THE CHAIRMAN: It is possible that occasions might arise where discipline of a number is necessary where suspension, perhaps, would be out of the question. It is not convenient or practical to suspend a whole class or half the school, and it was in reference to a condition like that that this question was originally put.

A MEMBER: I have found it more satisfactory to give the nurses who have erred in their department extra hours, and in that way it has been brought very practically to their minds; the offending members have been kept at home.

DR. KAVANAGH: We have adopted two general principles with good results. On an occasion when a number of nurses did something that was delightful for all of us, that was a beautiful piece of work that was recognized as such in connection with the hospital, we took, I think, two weeks off of their time. It was a small thing to do, but it loomed large in the eyes of the nurses to find that they were recognized and the work that they had done was recognized in that way. On the other hand, instead of suspending a nurse, which means a vacation, instead of that, add a week or two, or add a month to their course. That has been done and done with marked effect, and the punishment has been felt and felt keenly.

A MEMBER: I beg to differ with the speaker about suspension being a vacation for a nurse. I have never known a nurse to be suspended that has not been almost broken-hearted, so are the superintendent and sister nurses. I do not think it is considered as a vacation.

DR. E. B. SMITH: We advise our superintendent of nurses in a mild manner that she do not suspend nurses; we always advise her to keep them busy, not only busy with the work, but busy with a little bit of the social part of life. We allow them

to have long socials, and we have a place where they can dance or where they can have little parties in the winter. They have to have some sort of recreation, and if you cannot allow your nurses to go out at nights, let them have a good time at home.

MISS HALL (Seattle): It has been my experience that in the majority of instances, as soon as a young woman enters the training school, even on probation, there is a certain restraint, she begins to lose her individuality, and I think we have been making mistakes. I think in order to develop the very highest type of woman, the highest type of nurse, we need a good full free expression of life, and we get that best without a very great deal of restraint. To give you a little of my own personal experience, I have at present a school of sixty. I begin with probationers as soon as they enter, and first of all we consider the sacredness of our work. Then, just as soon as it is practical, they are taught to understand something of the hospital management, what the hospital depends on for its maintenance, and they get a personal interest in the institution. Then as we get along a little further, we have a course of inspection of the hospital and we invite criticism, we invite suggestion. We are not a perfect institution, we are very defective in construction. As a rule what the nurses see is considerably at variance with the theory. We do not want them to think that we think we are perfect, and when we get them to come to us, we get them to be co-partners with us. Then we have our class organization, each class is organized with its regular officers and I want to say, each class very, jealousy guards its own interests, and the question of discipline is settled for me in that way. Each class has its method of entertaining, and so on these lines we enjoy a very happy family life without a great deal of disturbance, and there is no question of disloyalty; they are made to feel in connection with the work that any little economy on their part is a direct contribution on their part. In that way they become stockholders or shareholders and we have no trouble. We have given in connection with our school some time to the development of the spiritual side of the pupil so that we have our regular weekly devotional services. We do not have them in the form of the prayer meeting as we understand it, asking for something. We come together with this understanding: that we are happy and have praise and thanksgiving for the privileges we enjoy. The nurses join in that way and they do not rebel, they come voluntarily and gladly, and we have thought that that largely assisted us in our work.



## DOMESTIC.

THE CHAIRMAN: I have asked Miss McCullough if she will take up the first and second questions in her paper to-morrow, and that brings us to the third and fourth.

Nos. 3 and 4.—3.—(a) *Which gives better results, a central linen room or an individual linen room for each department?* (b) *How can extravagance in the use of linen be controlled?*

4. *Prevention of excessive loss of linen while passing through laundry in hospitals in which the board does not feel able to provide competent supervision.*

MISS KRAEMER: I expect to have a central linen room to control the counting of linen and the giving out on requisition only to supply each floor. As it is now, usually about six hours after the linen comes up from the laundry, there is nothing on the shelves. My idea is to have all linen go to the linen room in the basement, which is in charge of the nurse, and all the linen mended, sorted and given out on requisition through the office, but my plans are not very definite yet. The linen is marked now for the different departments. The nurse makes out a list and it is checked up as it goes to the laundry, and when it comes back, so that everything is accounted for each week, which we expect to continue doing, only that the linen is to be taken care of in a central linen room.

MISS JOHNSTON: In our hospital we have for each floor a linen room. Until recently the linen room has been open to all, with the result that our linen comes up on Wednesday or Saturday; usually by Tuesday we are having demands from each floor of the house to apply to the laundry for linen. We have put doors on our linen closets now and they are locked, and the supply is given out each morning, if necessary again in the evening.

THE CHAIRMAN: You feel that the extra labor which this calls for is more than compensated in the results?

MISS JOHNSTON: Yes, we do.

THE CHAIRMAN: Is there any one here who has the central linen room in full operation?

MISS VANDERWATER: We have the central linen room. The woman that is in charge of the laundry sorts the clothes, and she has charge of the linen for the entire house and it is issued only



on requisition. I have a form for sheets, counterpanes, pillows, everything that goes out is on requisition only. I allow a sufficient number and if there is anything else to be gotten during the day they have to come to me for the requisition to be signed. We have done that for the last six months and I cannot begin to tell you the saving. It fully repays me for the little extra work. We have one hundred and fifty beds and we have only one passenger elevator and one freight, and I find in the day time it interferes with the elevator, and just before the nurses come on for night duty, the orderlies bring up the clothes for each floor and it works well in every way. This woman has charge of it and it takes her entire time. We have two women sewing and mending all the time. This room adjoins the laundry and there is a window between to slip the clothes through, or to slip the linen through.

THE CHAIRMAN: In the remaining few minutes we will be able to do very little with the question of domestic employees under the topics as presented, what can be done about the difficulty which we all experience in obtaining suitable employees, coupled with the question as to whether a sitting room for maids or smoking room for men or both will be any help in solving this problem.

MR. BUNN: Our experience has been, as it undoubtedly has been with all of you, that the servant problem is intensified in proportion to the number that we have to employ, but we find this, that it pays to treat them as human beings and not as the scurf of the earth as in many hospitals. We find in making schedules of the work that has to be done, and giving the help some responsibility so that they know what their work really is, that they are not to be at the beck and call of every one that might want to push them around, and when they are through with that schedule any time during the day, after being inspected by the head nurse in the ward, they have the rest of the day to themselves. We make the work just as equitable as possible all over the house, fix it so that each person, if he works carefully, and persistently, he can get off for a half hour in the morning or afternoon, and then we furnish some entertainment during the year, just as we do for the nurses; we allow them a party twice a year, under proper supervision, of course. Another thing that I would mention is this: that their work, when well done, must be acknowledged. For instance, I have a gardener who attends to the lawn who has worked as late many times this summer as nine o'clock at night in order that the lawn may bring forth appreciation from those who see it. A little matter came to my attention a day or two ago. A doctor

stopped and spoke to him and said, "The lawn never looked better than it has since it was under your care," and the boy has not forgotten it yet. I think he would work all night if more doctors would do that.

THE CHAIRMAN: Will you tell us something more about these parties?

MR. BUNN: We give over the nurses' hall for them two evenings, for both male and female, and we are present ourselves to see that the thing is properly conducted. They dance and have something to eat, just like an ordinary party. We give each girl the privilege of inviting whom she chooses, a male friend and each man a lady friend, and secure the music for them and furnish the food for the lunch, and we have had no trouble. We were surprised to see how well they conducted themselves. They appreciated it, and they have been very loyal since. I do not know that that has been done anywhere else.

THE CHAIRMAN: My own experience has been that social functions need supervision, that domestics have to be taught and looked after. In our new building we are planning for a recreation room for the domestics, but there is a great deal of doubt in my mind as to how we are going to make a successful issue of it.

MISS HARTY: We have not had as much trouble with the domestics, especially the female domestics, since we have given them not only a room, but a separate room on the grounds near the hospital. They have their rooms with bath rooms and sitting rooms and a screened porch and yard, and they are allowed to have their friends. I do not see how we can expect to have good help when we do not give each girl a place to have her friends come to see her; they have to meet on the street or some other place if they do not meet in their home. We have a matron living in the home for the female domestic help.

MISS CADMUS: I think much of the difficulty that we experience is due to the lack of proper housing and sleeping accommodations. A great many hospitals seem not to have planned very well for the sleeping accommodations of the domestics. Where I am now we are having great difficulty in keeping waitresses, and a great reason for it is that we are obliged on account of the floor space to use double-decked beds, and they object to the upper deck, and I don't blame them. Dr. Pratt, of the Smith Infirmary, I think, might tell us something about how it worked out with the very fine new home that has been built and opened for the domestics at that institution within the last year or two.

DR. PRATT: It has not worked out very well. We have a very nice home for the maids, and we have a sitting room for them which they never use. We have tried to give each one a separate room, and have done so as far as possible, but we cannot do that in every case. We find one of our greatest difficulties in keeping the home in condition, the maids do not seem to care how their rooms look, and it is only under strict supervision that we can keep their home in proper condition at all, and it does not seem to me that they appreciate the least bit what has been done for them in this line, and we have great difficulty in keeping maids for certain positions. There are some positions where they have been for a number of years and are still with us, but most of those who have come recently stay but a short time, so I cannot see that the home has really helped in any way, except that we have a suitable place for them, which we have not at present for the men, but which we shall have in the future.

THE CHAIRMAN: We are sorry that was so discouraging. Miss Kraemer, will you tell us of your experience?

MISS KRAEMER: When I came to the hospital in Canandaigua our servants were all sleeping in the basement. We have succeeded in taking an attic floor, not used for anything, and converting it into very nice bedrooms, and have a sitting-room and piano. We have also a bathroom for them. I find it a very great advantage and have no difficulty in getting very good help. The door is locked by the night watchman at 10.30. The servants usually spend their evenings at home very satisfactorily.

THE CHAIRMAN: Owing to the lateness of the hour, I think we will be obliged to leave the few questions we have skipped, and we may be able to take them up to-morrow. I want to publicly acknowledge my indebtedness to the associate chairman for a large part of the success for this evening, and thank you all for coming, and talking, and listening.

Adjourned until 10 a.m.

## FRIDAY, SEPTEMBER 22—MORNING SESSION.

Report of Committee on Constitutions and By-Laws, was read as follows:—

Your Committee on Constitution and By-laws, to whom was referred the resolution relating to the non-commercial exhibit, begs to recommend: That if the Association approves of the resolution, that the following amendments be made to the Constitution and By-laws:—

(a) Add to Art. 4, Sec. 1 of the By-laws “and a non-commercial exhibition committee of five members, including the Chairman.”

(b) Strike out the word “and” in line 8 of this section.

(c) Add to the article, Sec. 8, as follows:—

Sec. 8.—The Committee on non-commercial exhibits shall arrange annually for an exhibit of non-commercial hospital appliances. The Chairman of this Committee shall be an officer of the Association to be appointed by the President for a period of two years, and shall be allowed a sum not to exceed \$250 per annum to defray expenses.

Your Committee further begs to report that the allowance for the work of your Secretary is now \$360 per year; that this was a sum appropriated some years ago. The Association has since greatly increased in members, and the work of the Secretary has expanded in proportion. It is the opinion of your Committee that the important work of this officer should not be handicapped by a limitation of funds, and after a consideration of this matter with your former Secretary, Dr. Babcock, the following recommendation is proposed: That the concluding sentence of Sec. 3 of Article III. of the By-laws, read as follows:—

The Secretary shall be allowed a sum not to exceed \$600 to defray the cost of clerical assistance.

PRESIDENT: Under the By-laws of the Association amendments recommended by the Committee have to lie over one session. The Committee on Constitution and By-laws will bring that amendment again this afternoon for final action. Is there any discussion on this proposed amendment? Is there any new business to come before the Association? If not, we will take up the paper.

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## SOME PROBLEMS IN THE DIETARY DEPARTMENT OF HOSPITALS.

BY MISS GRACE E. McCULLOUGH,

*Dietitian, Massachusetts General Hospital, Boston, Mass.*

Every institution has its own distinctive problems, not common to many or any, they may be this or they may be that, but to each and all, the problems of food and feeding are burning questions to-day. There is more to it than to supply food at a minimum of labor, cost and material yielding maximum results of normally satisfied, well-fed and happy communities.

For ease in considering some problems of the dietary department, they can be arranged in three general groups—viz.: construction, organization and catering.

## CONSTRUCTION.

1. Institutional machinery must run smoothly. There should not be any grating or grinding. A different and proper construction of the working rooms, a reasonable amount of well-arranged, suitable equipment would have much to do with lessening friction.

In all cases the construction problem is local, but needing drastic measures, whether it be building new buildings, replacing old quarters with new, or reconstructing the old. In any case, the architect must be carefully watched by one who understands the needs. Architects may know how to design, estimate building costs and suggest material, but alas! few indeed know how to draw up dining-room, serving-room and kitchen plans, upon what may be called a practical working basis. Every extra step made necessary, every useless door, every misplacement of equipment has a financial value in the daily running expenses. Every extra cupboard has a definite cost to scrub and keep in order, plus the energy necessary to enforce the cleanliness. Dark corners not only have a cash value but are glaring facts which stand for ignorance, and many times as criminal carelessness.



Many new buildings used for dietary purposes are as faulty in construction as the very old ones. May I be pardoned if I draw upon my experience and observations? I know of one hospital with a census averaging between 800 and 900, where the kitchen is ideally located on the upper floor, without one drop of hot water at the faucets from 9 a.m. to 4 p.m. Can you estimate in dollars and cents, the friction of the grumbling and snarling of help and the waste of time to heat water for the washing and cooking of food for such a large number? In another, the storage of milk was apparently forgotten, to supply the deficiency, an *unlined pine* box, was placed on one side the kitchen near the coal range, this was kept half full of water, an ammonia coil cooled the water, and into this, were put the large dirty milk cans as they arrived from the railroad, careless handling invariably allowed the dirty water, soaked from the outside of the cans, to splash into the milk every time a lid was removed; also, that the daily cleaning of this water soaked, smelly box, reduced the temperature 1 degree throughout the entire refrigeration plant. Another well-located kitchen had four little rooms leading off, each with four upper and four lower corners, to be daily inspected, four extra doors to wash and four sets of brasses to polish. To keep those four rooms in order, required half the time of one man at \$18.00 per month. I beg of you, Superintendent, Doctors, to tear out the unnecessary partitions, just leaving the four walls and make your dividing spaces be the working divisions with convenient, movable tables; place all possible motor equipment upon the side nearest the work for which it is intended. I know of a potato paring machine next the butcher's block, with the vegetable corner at the other extreme end and the meat grinder next the ice cream freezer. An apple parer, with a wonderful speed record, so close to the corner, that a barrel and the operator cannot be there together, consequently one apple at a time has to be pared instead of six. In another, a potato parer was an

after-thought, the little cuddly hole containing three machines and a motor was too small to admit another, so a hand machine was secured, and for three consecutive hours every day did a Greek boy at \$18.00 per month, turn the crank to supply the demand. In another, the food elevator from kitchen to serving room, was too small to hold ordinary sized food containers; built upon the dimensions of those in hotels for individual orders, consequently to facilitate the service at rush hour, the containers were put in sideways and there was a continual spilling of greasy food upon the elevator shaft as well as upon the shelves. The cleaning of that elevator shaft was a perpetual nightmare, it was run by electricity; the hospital might be responsible for accident, so a man to clean and a high-priced electrician to stand guard, cost a few dollars at the end of the year. Another has the full steam equipment so wonderfully and compactly arranged, that it is impossible to clean it without the risk of maiming or even the life of the cleaner. The huge boilers remain hot a long time, while pipes and valves burst without warning. The splendid kitchens of the large German hospitals, especially in Berlin with the absence of kilometres of black-lead pipes were a great pleasure to see; surely some such method can be adopted here; there the boilers are as large, the steam arrangement adequate. Surely, we can wage a war upon steamfitters and plumbers for better results, so that the boilers, tables, dish-washers, etc., need not be such unsightly, impossible-to-keep-in-order affairs as they are at present. Floors and windows are open questions. The material for the floor is frequently determined by the amount of money available, that it must be hard, non-absorbable, easily cleaned, and, if possible, arrange that it may be hosed each week at the least. Must we continue to swab the floor whether of soft pine or white marble with the unsanitary mop? And go on risking life and limb cleaning windows outside from the height of the sixth, seventh or eight stories, when for a very little expense, hinges can be adjusted to

swing the present sashes inside, to be washed by the help at hand whenever necessary and not have to wait for the annual, even bi-annual, visitation of the window washers. The size and method of the refrigeration plant is an individual question depending upon the locality, size and needs of the hospital. It came to me, while passing along a street, in front of a restaurant, and saw blocks of ice of unusual shape, 5 feet long by 1 foot wide by 9 inches thick, having notches at regular intervals that, instead of the large blocks of ice, as we have it would be desirable in many instances to have small ones which would fit into the regulation ice chests upon the wards and thereby do away with the labor and consequent waste to crack into proper size.

#### ORGANIZATION.

2. As the strength of every organization is only as strong as its head, the primary problem is the securing of a suitable dietitian as the head of the dietary department; upon her should rest the responsibility of a simple, comprehensible organization, with a check upon the many avenues for waste, and theft, dovetailed into the other departments, for all are interdependent. Those of you who have tried, know the difficulties attending the search for the right one. What is wrong? Personally I think it lies in two directions. I beg you to accept the fact of a new profession in a state of evolution. The pioneers were few, they had to work cautiously, feel their way and not until the value was proved upon the credit side of the ledger was there any hope of permanency. Many hospitals recognize the necessity for a change in their dietary department but do not know just what they want, and instead of adopting an entire new system, propose to graft new ideas upon the old regime with its division of labor. Old customs die hard, and echoes of the wake return periodically. While on the other hand the technical training schools, and even little cooking classes connected with the Young Women's Christian Associations are turning out so-called dietitians, a lot of inexperienced

young students, fresh from college; truly, sweet girl graduates, but absolutely incompetent to grasp the full scope of the work or with force to develop it; though considered to be technically trained and by their miserable failures throw discredit upon the profession. *They come cheap.* I know of one large institution with a census of 2,000 priding itself upon having five dietitians, the salary of each being \$35.00 per month. To my mind that is the poorest economy; \$2,100 goes out annually in salaries to inadequately trained people. Would it not be wiser to expend this sum of money in securing an executive dietitian, scientifically trained, of mature years, with a progressive outlook, at a salary of \$1,200 to \$1,500 per year, an assistant at \$500, and spend the remainder for better grade cooks, thereby saving the board, lodging and laundry of three, and at the same time secure better service, smoother machinery and wider results? I also know of another large city hospital with 1,000 beds, which very recently, upon pressure of the visiting staff, decided upon having a dietitian. The selection was a little, delicate girl about 22 years of age, with nine months' training. She was expected to reorganize the department, cope with a chef who had been there 27 years, make possible a new system of ward diets, and develop a diet kitchen. It was a stupendous undertaking and called for the very best. At the end of three weeks she came to me and asked what I did about milk diets; but was unwilling at first to say what hospital it was. So you can imagine my surprise when she stated the name, as I knew many of the medical staff and had visited it. There are dietitians and dietitians. All the way from the man who insisted he was one because he had heard Liebeg lecture once upon dietetics and believed in it ever since, to the few who have grown grey in the service. To be a success in the work, the dietitian must be an all-round woman, with technical training and as much as she can get. To be equal to the practical side she must have great executive ability, an abnormal amount of common sense, tact, infinite

patience, and excellent health; she must be able to satisfy her large family, and at the same time maintain an economic standard. She must be a teacher, for connected with all hospitals of any size, are the training schools for nurses, with courses in dietetics and special diet kitchen, where up-to-date methods in determining the value of foods from a caloric, nutritive and digestive standpoints. Last, and certainly not least in importance, is the ability to render intelligent assistance in the diet of diseases, especially those of the gastro-intestinal tract, where diet is the primary treatment and in the diseases of infancy. The dietitian who does not see her department as a composite whole, fails in her full stature; if she allows detail to absorb her time and hide the broader view, the hospital will suffer.

She should possess the confidence of the head of the institution and receive his endorsement. She should be granted the dignity of an officer of the hospital. Having executive ability, she will reduce labor to the minimum: for the help problem confronts us all. Such questions as, how to select help? What salaries should be paid? The division of labor? How shall we contentedly feed them? are open for discussion. It requires the utmost tact to maintain order, good-will and lengthy service. The energy expended in continually teaching new and incompetent help could be so much better employed. I feel it worth while to pause and try to develop some simple method to make them loyal to the institution and have pride in their work. Apart from the usual questions concerning help, there is an entirely different phase of the subject and that is the frequency of syphilis among them. We heard lengthy discussions during these meetings of how to wash hands. I wish the waiter who handles the bread, the dishes, and rubs everything in sight with an unsightly cloth, could be made to wash hands. I was about to say, I did not care how. I have been obliged to discharge both men and women because they had active cases. We wash salad through many waters only to have it infected



of more loathsome conditions. Help which are hard to get and harder to keep will not submit to any sort of examination.

3. *Catering*.—Under this heading belongs every detail which concerns the food proper, nothing of the workshop or of the workmen, but the material, both raw and cooked. Its income and out-go, the purchase, the price, the care, the waste, and the best methods of reaching the desired results. It is an art to know how to buy. The purchase of raw food material must be made by one who thoroughly understands the local markets, the seasons, the State laws controlling the various products, and last, but not least, know the requirements of the institution. Nothing but the best should be purchased; it is cheapest in the long run. Shall the hospital purchase by contract, or upon the open market at wholesale, plus a cash discount? Shall the institution, if large, have a purveyor or will the Superintendent, dietitian or steward do it? In any case the quantity and price should be the prerogative of the dietitian to control, as she is responsible for the per capita cost of sustenance. The storage capacity frequently determines the amount which can be purchased at one time, very often excellent prices can be secured for staple groceries if the season is dull. If groups of small institutions combine for annual quantities, good contract prices can be made for the increase quantity; but nothing will be gained when the saving is absorbed by the salaries of inspectors who pass upon food and determine standards.

Meats purchased by carcass do only for the very large institution and even then I strongly recommend the addition of cuts, while for the small institution only cuts should be considered; they yield better results, not any more in price when all sides of the problem are taken into account, and certainly give greater satisfaction. It takes large numbers of free wards, and many help to consume the stew, the hash, the corn beef and the left-overs. A weekly supply can be stored safely and advantageously, if a refrigeration



plant be installed. A refrigeration plant to-day is not the large expensive problem of a few years ago, but comes within the radius for capacity to meet the needs of the average householder, apartment house and hotel. Fruits and green vegetables should never be purchased by contract. I know a city institution where an excess of 50 per cent. above retail were prices were paid. Bananas alone cost 22 cents per dozen by the bunch, when in any fruit store, a single dozen could be bought for 10 and 12 cents. The vegetables came in the most unsatisfactory manner, and frequently had to be returned as unfit for use.

There can be definite per capita quantities for facility in purchasing, but the institution will certainly cripple its department if there be a fixed daily per capita cost. Let the cost be the least for the desired results. Sometimes the pleasure of a feast one day may compensate for a famine the next. The character of your household must be taken into consideration. All the research, the established facts of balanced dietaries, calories, etc., have not yet made their impress upon human appetites. Complaints come from all quarters, and cannot be ignored. They want what they like and will not eat anything else. From the pauper, who when well, insists the world owes him a living, when ill wants a little more, to the rich with satiate appetites. Nationality cannot be ignored, and often this problem can be easiest met. For instance, I was asked by a hospital to look into a question for them. The larger number of patients were Italians—both rich and poor. It was practically losing its prestige, convalescence was slow, and the food seemed the chief source of dissatisfaction. After three days I merely recommended a change of one cook, substituting an Italian for an Irishman, and that the *plat du jour* be a true national one. The change was made without one cent additional cost to the hospital, and the psychic effect so great that the other food was acceptable. The rich should have what they want,

provided they pay for it and it does not interfere with their recovery, but it is one of the very weak points in many hospitals that the private patients are expected to pay the full expenses of the dietary department. This is not a rash statement, but the outcome of a long discussion between several superintendents, doctors, and myself, in Berlin. One hospital, whose private patients number 80, has the entire cooking for them done in what is called a diet kitchen, by relays of probationary nurses, under the direction of the dietitian, and is known as "the course in dietetics." Of course the patients are dissatisfied; you would be and so would I—twelve young girls, in three sections, absolutely without any knowledge of such work cannot be expected to prepare food for those who have been accustomed to expensive chefs.

*Bread.*—It would be interesting if all the inquiries concerning bread had been tabulated. The cost, the quality of flour and where shall it be made are included in all lists of questions, as it is, in many hospitals, a weak point. I have but one opinion: that hospitals located in cities having less than three hundred beds will find it cheaper and will find more satisfaction to purchase made; rather than to make; but a standard must be established and maintained. The law requires sanitary bake shops, and full weight, for a given price, the hospital giving strict surveyance of its contract bakery, will do well for itself and also for the community. Bread should be made by an intelligent person, and trade labor is not cheap, the salary of the one who can turn out 200 loaves of bread daily, uniform in size and quality is qualified for 2,000, the heat which will bake 200 loaves may be made to bake the 2,000, and thereby decrease the cost of production; the price of material in the larger quantity will be proportionately less than in smaller lots, and there will not be the periodical wail of bad bread, with the overflow in the garbage pail. At Berlitz, I visited the bakery connected with the sanitarium and found many sugges-

tions which can readily be adopted, most worthy of note were oven carriage and broad oven door. The salary of the baker is greater than the resident physician. The bakery supplies the bread and rolls for the general hospital and also the tuberculosis pavilions a mile away. Shall we have six-pound loaves, similar to Dr. Howland's "big stick" or the pound loaves, with 2 ounce waste upon each, and nervous prostration to dispose of the ubiquitous crumbs?

*Waste.*—The waste problem can be traced to three distinct channels—

I.—Unsatisfactory providing.

II.—Improver serving.

III.—A lack of care in the left-over.

Needing eternal vigilance from the beginning to the end. Where must the responsibility be placed? Unquestionably, upon the dietitian, by supervision, through her enforce upon each department of the hospital handling food. With a careful inspection of the garbage pail, such as the admirable system in use in the Massachusetts General Hospital. (See Dr. Howland's Pamphlet.)

The first and third belong to the kitchen. The second the serving rooms, whether connected with main dining-room or ward pantries.

*Summary.*—Briefly summarizing, we find included with in the dietary department of the general hospital separate and distinct sections, corrolated into a composite whole. The well to be fed equally with the sick. The special case demanding comprehensive work and a diet laboratory. The feeding of and for the doctors, their idiosyncrasies and those of their patients. The training of the nurses along progressive lines as well as proper food to maintain the standard of duty demanded, and last, from the depths of my heart affirm not the least or the easiest, the feeding of that large army of employees required to make possible the manipulation of such intricate machinery. No cut-and-

dried methods any more than rules can be formulated to meet the needs of all institutions. The best results can only be obtained when the department is controlled by a suitable head, with adaptability sufficient to apply the best from all available sources to improve conditions.

PRESIDENT: This subject is very close to us, it is a very practical and important subject. Most of us are working it out perhaps on somewhat different lines. We want to hear from many of you as to your experience. The discussion will be opened by Miss Emma A. Anderson, of the New England Baptist Hospital, Boston.

#### DISCUSSION.

MISS ANDERSON: I for one shall hope to have that excellent paper that has just been read as a hand-book and kept near for reference. I want to speak of the small diet kitchens as found in many hospitals on different floors of the building as opposed to one large, central diet kitchen. It seems to me that a central diet kitchen of good size, even if more steps have to be taken to distribute the food, is much better than the small diet kitchen, where the nurses are huddled together and handicapped at every point. I was much impressed from my own experience on the point that was made in regard to the economy of getting the right woman to take charge of the dietary department. Perhaps we are apt to make a mistake in the beginning, thinking a cheaper woman will do. I found one year a woman who came to me and insisted upon nearly twice the salary that I thought I could pay, I finally engaged her at her own price and I am sure she installed in the first year labor-saving machinery and made changes enough that covered her salary, and, of course, the benefits that she installed have continued ever since. Nothing was said about a dishwasher. I am hoping some time to find some one who has a dish-washer that really is adequate and does the work economically. In our hospital the dreariest work of all is the dishwashing. Getting food to patients hot. In building new hospitals, arrangements for that will be made, but many of us still have to handle the problem in inconvenient, poorly constructed hospitals; that must be done in some way, or the patient will not be satisfied. In surgical work we all know that after the surgeon has finished his job and the first few days of the discomfort of gas pains are over, the next problem is to feed the patient, and if we can do that we can keep

him happy. We must get the food to him hot. We have such long distances to travel in our hospital that I have to have one set of nurses getting out food, another set of nurses waiting to snatch the trays and get them to the patient. We serve the food on hot water plates to patients that are at a distance. If we feel that food must be served hot, we will find some way to do it. I want to touch on that question of baker's bread. As a New England woman, when the thought first came to me it seemed to rank heresy that any bread made outside of the house could be fit to eat, but the time came when I had to add one more servant in the kitchen, or else take the bread-making from the cook, and we found that taking away that one item saved the salary of one servant, and I am sure the bread is better and it is more economical. You know how the homemade loaves taper at one end and you lose at least two slices from the end of each loaf, and the baker's loaf is uniform and I am sure it is economical to use baker's bread even in a small hospital.

DR. GRAHAM: I think one of the main difficulties why this problem has not been settled more fully has been the lack of co-operation of our own profession. Strange to say, but I think it would be the testimony of almost every hospital superintendent, that it is very hard to get the busy practitioner interested in the subject of diet. As long as the patient does not complain to him about the character and quality of the food, as long as he is not embarrassed himself, he is willing to let the hospital work out the proper food for the patients. I think the Association is to be congratulated on having the opportunity of listening to such a comprehensive paper that contains so much in such a small compass. The problem is a problem from the standpoint of health, the standpoint of the purchase of the supplies and preparation of food. We are often handicapped by appliances imperfectly arranged or insufficiency of room. I presume every one here can recall certain of the newer hospitals, those that are constructed by a body of people having little hospital experience, the difficulty of getting proper conditions for the preparation and serving of food. I can recall in this city a new hospital in which the dish-washing and the serving of food for thirty-two people was to be accomplished in a room that had a clear space of five feet by about eleven, a space in which two people with a tray could not pass side by side. The dish-washing was to be done in a sink that was 16 by 20 and on a drain board that was 18 inches long. I also have had a more recent experience where the cooking for fifty people was to be done in a diet kitchen that was 8 feet wide by 15 feet long. You know it is absolutely impossible to do anything unless the hospital furnishes the proper facilities, and I think that is one of the big problems. The prob-



lem of help we can hardly ever expect to be solved, because it is becoming more acute every year, but I do think that we should insist upon more assistance from the medical men in the desire to furnish our patients with better food. I question if there are very many hospitals, for instance, in the United States, where such things as a balanced ration is ever thought of in connection with the food of the sick. I think a cursory inspection of the average bill of fare of the average hospital will show that there is a great deficiency in that line.

DR. HOWARD: Miss Anderson spoke of a dish-washer and that she had found none that was adequate. The dish-washer cannot be efficient unless the water is boiling. There are many dishwashers that are all right, the only trouble is you want to study the intent of the machine and if you will use your brain you will get an efficient result. I know half a dozen that are first rate. I should keep the simplest thing I could, but I do not care whether it is a small or a big hospital, there are dishwashers that are adapted to both.

DR. ROSS: Since the days of the fireless cooker have come into existence, the suggestion has occurred that the conveyor of food could be built on the same principle. We have established one along those lines and I am pleased to say that we can put a meal in that conveyor of food and keep it warm for two hours, so warm that it is uncomfortable to eat the food if it is started in absolutely warm at the beginning.

DR. GRAHAM: I wish to make a suggestion in regard to a dish-washer which I think will be found useful. Some of them are supplied with it and some of them are not. The last speaker said you must have an abundance of hot water, the water that finally rinses the dishes should be boiling water, but if the dish-washing machine is arranged so that there is a large outlet at the water line, so that a pipe admitting a small quantity of hot water will cause a constant flow of the surface through that large outlet, it will remove the very thin scum of grease that is so often a source of annoyance in dish-washing, and the dishes will come out of the final water absolutely free from that.

MISS KEITH: I should like to ask Miss McCullough why the graduates of some of the domestic science schools are so reluctant to undertake the care of food in training schools for employees, why they insist on confining the supervision to the food for the invalids, and I should also like to ask if it is possible or practical in a small hospital of perhaps thirty to fifty beds that the dietitian might also act as housekeeper.



MISS BURGESS: I should like to ask whether it will pay a small institution of say eighty to one hundred beds to put up their own fruits, or whether it is better to buy it already canned?

MISS McCULLOUGH: My experience in putting up fruits in the hospitals is that we get better results that way, the taste is better, but the expense is no less, when you take into consideration the price paid for good fruit and sugar. At the Massachusetts General we put up about three thousand quarts of fruit every year and it is very acceptable. Many of the patients enjoy the currant jelly because it tastes homelike and we have very good results, but I do not think it is any cheaper.

PRESIDENT: Will you kindly answer Miss Keith's question?

MISS McCULLOUGH: I do not think they are really earnest in their work. I feel a dietitian should accept the whole situation, and feel that she is responsible for the entire food of the institution. As you know, there are a great many nurses who want to do this and do that without doing the whole thing. I think it is a mistake of the dietitian herself and not of the general profession. A great many of the dietitians are turned out who do not mean to make it a life work, and they want to get along with as little work as possible. I do not know that that is the general feeling, but it is true of some of them, especially with the very young. The very young ones are not able to take care of the help problem and they do the thing that is easiest.

MISS KEITH: In a small hospital of twenty to thirty beds, I should like to know if a dietitian might also act as housekeeper—if those two officers might be combined in one person?

MISS McCULLOUGH: Their training includes full housekeeping, care of laundry and things of that kind. If they are willing to accept a position in a small hospital, they can very readily do it, but I do not think they can be secured at the small prices that the small hospitals are willing to pay for the double work. Many do not wish to pay more than \$60 a month for the dietitian. If I were superintendent of a small hospital I would have a dietitian to be responsible for both, but I would have another person who would be responsible for the general work.

MISS KEITH: If you were superintendent of the small hospital of which you speak, what would you expect to pay the dietitian that occupied the double position?

MISS McCULLOUGH: Not less than \$1,000.

MR. COSGRAVE: Referring again to the dish-washing machine, I do not think there is any question at all as to the perfection and suitability of the dishwashing machine if you work it right. All

our hotels and restaurants have them. I saw some machines working this morning in the kitchen of the Waldorf-Astoria, but in a hospital it is a question whether it is advisable or economical to have the dishes sent to a central dish-washing room from every one of the serving rooms in the institution.

DR. PIVOTO (Texas): Speaking of the regular dietitian employed, will that person be expected to teach the nurses—would she be a teacher in the diet department for the nurses' training school?

MISS McCULLOUGH: Unquestionably the dietitian would be expected to train the nurses. May I say a word about the dish-washer? In the small wards it would be well to wash the dishes at the sink and have a sterilizer in which all the dishes can be placed and which would not occupy much space. That has been done in the Massachusetts General.

MR. PARKE: When I first came to our hospital the trays were carried from the little kitchen attached to the private wards, each little tray directly to the room. Now, we have a wheel carrier that carries twelve, the trays are fitted up on the carrier and everything is put on that will not be hurt by standing a short time, but everything, for instance, the soup dishes and the hot water plates, and at the last instant the warm dishes are put on there and a tray lifted off at each door. As to the dish-washer that Mr. Cosgrave told us about, we saw that at the Waldorf-Astoria, and they told us that it had been in use eighteen years and the dishes were all right. I asked about the breakage, and they told us their dish breakage amounts to \$180,000 a year. Seeing the men handle them, one cannot be surprised at that. There are two questions I should like to ask: Where do you divide the line? Where you have a dietitian, have you any use for a steward, and if you have a steward what do you make him do? The other question is on refrigeration. We have had a long discussion over the question whether we would use in our new refrigeration plant the old system of ammonia absorption, or the carbon dioxide. I should like to know of anybody that has had experience with both ways.

PRESIDENT: I will take the liberty of answering one of those questions of Mr. Parke. I have had experience with ammonia and carbon dioxide methods of refrigeration. I think there is no comparison. The original cost of the carbon dioxide plant is larger than the ammonia plant, but we would not go back to the ammonia plant if we had to go without a plant. I think the cost of operation of the carbon dioxide plant is even less than the ammonia plant if it is properly constructed and has greater safety, in my opinion. Miss McCullough, will you answer the question as to the steward?

MISS McCULLOUGH: It depends on the size of the hospital. If you have a large hospital, the steward is responsible for a great deal more purchasing than merely the food. I have not very much experience with small hospitals. The smallest hospital I have ever had has been the Massachusetts General, and I began with about twenty-five hundred to cater for, and at one time I had four thousand, so I do not know anything about the real small hospitals. There is a great deal more to be purchased than just the food proper. In a very small hospital I am sure the dietitian, if she is well trained, is competent to do more buying than the purchase of food and in that case I do not think the steward is necessary, but if we are willing to pay a suitable price for a suitable dietitian, she is competent to do more than the ordinary dietitian and her training in all lines of work would make her competent to purchase linen and everything except surgical supplies. If I had a small hospital I would rather the dietitian did the entire purchasing of the food than to make her the housekeeper and supervisor of the laundry.

PRESIDENT: Do you wish to say anything further in closing?

MISS McCULLOUGH: Nothing, except that I want to recommend to all hospitals that when they purchase improved tables that they make them three or four inches higher than they usually are. We have had the most excellent results with high tables. You will find your help will not get as nervous working over a high table as over a low one. I had a fight to get a table of suitable size. You can have one lower table where eggs can be beaten, but all the other work can be done with high tables just on an elbow line with the worker. You can get the high rubber table ends that will raise it about that high, and you will find very much better results by having high tables.

PRESIDENT: The question is asked what is the best manner of buying eggs and butter, whether by contract or not?

MISS McCULLOUGH: I do not like contract butter and certainly not contract eggs. I am always afraid that the butter purchased by contract was secured when the contract was made and I am very certain that the eggs were purchased when the contract was made in many cases, and I am very doubtful of the eggs and butter from what I have heard in New York since I have been here the last

few days, butter and eggs purchased by contract, it has been most deplorable. We have to have cold storage eggs, but there is a limit to cold storage eggs. There is a very valuable egg tester on the market now which is run by electricity, it is very simple, and it seems to me feasible to anybody who wants to use it. I saw it in use and it is a small cylinder about that size, with an aperture in the centre and a tube at the top in which the eggs are put and the light shines through. If they are good or bad, the operator touches a button and the good go one way and the bad go another. It is manipulated by a key, and if any one uses, as I do, 2,400 eggs a day, it saves a lot of time in breaking bad eggs.

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## REPORT OF AUDITING COMMITTEE.

To the President and Members of the American Hospital Association:—

Your Auditing Committee beg to report that they have carefully examined the books, vouchers and statements submitted by the Treasurer, and find these correct. The balance of cash on hand and in the bank we have been unable to verify, as through an oversight on the part of the Treasurer the bank book was not placed in our hands.

Respectfully submitted,

J. M. COSGRAVE.

WM. L. STEEN.

PRESIDENT: The report of the Auditing Committee will be filed. Any new business? Any further reports of committees?

DR. TRUESDALE: For the Committee on Constitution and By-laws I should like to say that the allowance of the work for the Secretary is now \$360 per year. This was the sum appropriated some years ago. The Association has since greatly increased in numbers, and the work of the Secretary has expanded in proportion. It is the opinion of your Committee that the important work of this officer should not be handicapped by a limitation of funds, and after consultation with your previous Secretary, Dr. Babcock, the following recommendation is proposed, that the concluding sentence of Sec. 3, Art. III. read as follows: "That the Secretary shall be allowed a sum not to exceed \$600 to defray the cost of clerical assistance."

PRESIDENT: If there is no objection, under the By-laws this proposed amendment to the Constitution and By-laws will lie over for final action until the next session. The next thing on our programme is the Question Box, in charge of Captain Townley.

CAPT. TOWNLEY: It was the desire of the chair to classify all the questions, and as far as possible to obtain specialists to reply. Unfortunately, some of the specialists that were requested by the chair declined, and others were unable to be present. Again, unfortunately many of the questions were handed in at such a late hour this morning that classification was almost impossible, and any question where no person is designated to open the discussion, the chair will be obliged to ask for volunteers. Is Dr. Wayne Smith present? I will have to ask for a volunteer to open the discussion on these questions.

Question 1. *What is the best method of dealing with the race question in general hospitals in the Southern States where it is impracticable for white and colored patients to occupy the same ward?*

DR. WAYNE SMITH: We have put them in two separate buildings, white and colored; cannot mix them up at all.

Question 2. *Can the ward cases be best nursed by white nurses, in a training school?*

DR. WAYNE SMITH: We do that in our hospital.

Question 3. *If colored pay patients be received and retain colored physicians, what nurses can best be employed?*

DR. WAYNE SMITH: That is a question I cannot answer.

Question 4. *If a training school for colored nurses can be established, how can such nurse be best classified?*

DR. WAYNE SMITH: That is another question I am not familiar with.

Question 5. *What is first cost of furnishing completely a room for private patients in a general hospital? Also, the first cost of providing each ward cot and its full equipment? What is the average annual cost of maintaining each of the above, including renewals, bedding, etc.?*

DR. FISHER: I missed getting these questions last evening, or I should have been glad to find out what it cost to equip our wards and private rooms. The wards we fur-



nished twenty years ago, the private rooms very recently. This question of cost seems to me a question of latitude and longitude. When our hospital was first furnished the furniture was oak and really very satisfactory, but after it had been in use seventeen or eighteen years we thought it was rather obsolete. It has been re-dressed so many times that we thought we had better change, and so a committee from the Board of Directors was appointed to decide upon furniture for private rooms. We had seen mahogany furniture in somebody else's rooms, and we would not be second to anybody, so we got mahogany furniture—highly polished bureaus, tables, washstands, writing-tables, commodes, etc., and we paid the usual price for furniture of that sort. The bed was a brass bed, instead of an iron bed painted white, as it was before. We did not furnish all the rooms at once, we opened some new rooms a little later and got some more furniture. One day a maid came to shampoo a lady's hair and upset an alcohol bottle on the bureau which defaced the polish, and this good lady said it would be so much nicer if we had plate-glass on there, and it would save the tops, and if we would get plate-glass she would pay for it, and so we ordered the plate-glass. Then came the breakage in plate-glass tops—and what it costs to furnish a private room and maintain it depends on a good many factors. I regret that I do not know just what it cost us; I am perfectly willing to give it, but the figures are not in my head at the moment. And then it depends, of course, on what kind of work is being done in the hospital that has to be furnished. In hospitals where there is very active service and such cases taken care of as surgical, typhoid, pneumonia, and that sort of thing, the requirements are much greater than in a sanitarium or hospital where chronic conditions are taken care of and where sheets and pillow cases have to be changed so frequently. And occasionally when the patient is known to be going out in the afternoon the nurse puts on clean sheets that same morning, and they

are all swept off in the afternoon just the same as the soiled ones; that adds to the cost. I do not think it is done very often, but we have all of us experienced that same thing. I believe our standard equipment is ten sheets to every bed, that is fairly liberal, but it is not enough sometimes, and everything else is in that proportion. Some would call it generous and from some standards it is, and it is not so very generous from some other standards. The annual cost of maintaining, I think, I have answered that; it depends on how these things are used. I do not know that I have any figures anywhere which give the actual cost of maintaining an individual cot; I do not think we have averaged it up in that way.

Question 7. *Has any member of the Association had practical experience with linoleum floors?*

DR. HOWARD: I do not know that any of our hospital men have had long enough experience with linoleum floors except on the continent. I know what they mean exactly when they talk about foot prints on linoleum floors. When they make this linoleum, the last thing they do is to work up a finish on the top. Until that finish has been worn for a while, it seems to show every track easily. There is an English linoleum that is made by a good firm, probably as good as any linoleum made, and it is always made without that high polished finish, the same on the 16-millionth part of an inch on the surface as it is clear through, and it does not show tracks, either. Why the ordinary linoleum people put this finish on the top of it I cannot quite understand. The linoleum people put down a little piece for me recently and accidentally overturned the cement on the linoleum as they put it down—I always use linoleum cemented down—and in cleaning up the cement they used a little wood alcohol and the wood alcohol took off this polished surface, and they kept sending in bills and I kept sending in word that I should like to have the linoleum put in good shape, and it finally resulted in a long letter, and

they said, of course, that the surface could not be restored; they would do the best they could do and they tried to remedy it. It was a foolish piece of business from the hospital standpoint and everybody's standpoint. If you buy English linoleum, it is the same clear through and you will not have any trouble.

CAPT. TOWNLEY: What makes the best runner for a terrazzo or tile?

DR. HOWARD: I use linoleum and then I cement it down on the terrazzo, or in a tile corridor, right in the middle. It makes a splendid runner. I want to say a word about Dr. Fisher's sheets, if I may go back to that just a minute. We are frequently pulled up on the number of sheets, and we are frequently compared with the big hospitals on the continent. There is one that I have heard mentioned here a great many times this week which I at one time was very severely talked to because I could not run it at the same per capita cost; it has a high reputation and some 2,000 beds, but I happen to know that one of the little things why I could not was because their allowance per patient per week was two clean sheets. I said I could not compete with that at the same per capita cost. When the doctor speaks of ten a day, you can see he is talking about different things.

DR. FISHER: I did not not say ten a day; I said that was our standard supply for the ward—ten sheets per bed; if we had twenty beds to that ward that would be 200 sheets and something in the way of blankets. We have a standard supply for every ward, and every three months we take an inventory of those supplies to see how many have disappeared, or whether there has been any shifting about, some things being in one ward which belongs in another. But we have a standard of ten sheets for each bed in the ward, but not ten sheets a bed.

MISS KEITH: May I ask Dr. Howard if linoleum put on a terrazzo floor will stand mopping, or will the water from the mopping eat away the edges?

DR. HOWARD: Water does not eat linoleum.

MISS KEITH: Linoleum does not stand soaking in water, and if it is at all warped, would it not get under the edges?

DR. HOWARD: Not if it is cemented, the water will not get under the edge. Dr. Washburn has tried it in that way for several years.

MR. STEVENS: I noticed in Germany this summer that a great many of the hospitals have the linoleum floors, and this plain surface was overcome by a surface that was colored much like the color of the terrazzo floor. I tried to investigate that and tried to get in in this country. I find from the linoleum dealers that there is in some way an excessive duty on linoleum which is made of that character.

DR. FREELAND: We are contemplating new pavilions, and we are putting a runner on the terrazzo floor. We have decided on a linoleum floor on a level with the terrazzo floor by sinking it about one-quarter inch, and in order to prevent the breakage of the linoleum at the terrazzo floor a strip of 6-inch marble slab will form a border on either side.

DR. ANCKER: What is the object of putting anything on so fine a floor as terrazzo, or the tile?

CAPT. TOWNLEY: Will Dr. Washburn answer that question, or Dr. Howard?

DR. HOWARD: I know why it is done sometimes, why Dr. Washburn started to put it down, because there was a slight incline where he first used it; that floor got polished and once in a while somebody would slip on that incline. Sometimes they put it down for quietness' sake. I do not know of any better way, if you are going to put it down, than the way Dr. Freeland just spoke of. I think he has got that sized up.

DR. ANCKER: I suppose I will be put down as a disagreeable person, but I am opposed to anything of that kind on a hospital floor. We have had very considerable

experience with hospital floors; we have tile floors and we have maple floors, our maple floors are highly polished and almost seamless, that is, as far as any seam that would carry dirt is concerned. I have never known anybody to fall on those highly polished floors, and they always look beautiful, and I have never heard anybody complain of the noise. I have always maintained that the proper floor for a hospital ward is the tile floor; it is incomparably, I believe, the best floor that is used. As for being hard on the nurse's feet, or making a noise, I do not think that is true. We have many thousand feet of this flint tile, the hardest tile that is made, this imported material, and we have never had any complaint about the noise, and it is so easily cleaned with a rag and a little soap. In laying your linoleum you have got to have the foundation perfectly smooth and level, then you have got to have a perfect cohesion; I mean by that you have got to have the material used in cementing so distributed that there will be perfect cohesion, otherwise water will get underneath. Another thing, linoleum is a quarter-inch thick, and surely you are going to have an accumulation of dirt on the other side. In some of our corridors we use grass twine rugs or runners, and they are easily cleaned with a vacuum cleaner or put out of doors. I certainly do not care for linoleum floors.

DR. TRUESDALE: I have 100 feet of battleship linoleum laid after the method described by Dr. Freeland, and it is right on the floor level. It has proved very satisfactory, but I never wash it. I do not think linoleum ought to be washed. I think that you can detect an odor in a hospital where linoleum is water-soaked. The battleship linoleum can be polished just like a hardwood floor and I think it will last as long and you have no odor from it.

A MEMBER: I would like to ask if the linoleum is in such a position that the outside dust is carried in, and how does he get rid of that?



DR. TRUESDALE: The linoleum is cemented down, no dust gets under it.

CAPT. TOWNLEY: How do you clean it if you do not use water?

DR. TRUESDALE: Just as you do a hardwood floor; you do not wash a hardwood floor.

A MEMBER: We have placed it a quarter-inch below a marble base, and we find by covering this linoleum with shellac mixed with wood alcohol, it gives it a very nice polish. We just wax it the same as a hardwood floor and we get beautiful results. Each morning the floor polisher goes over that with a weighted brush, and it looks very beautiful.

MR. ROTHSCHILD: As to the sanitary effect of linoleum floor, as far as I can understand linoleum is made of a porous substance, covered with some varnish. Now, it often happens that varnish will crack, then air will get under it and it will absorb almost anything that is absorbable on a floor. If any one can explain to me that linoleum is a sanitary floor covering for a hospital, I would like to hear it.

MR. STRASSER: We laid in our hospital four and one-half years ago linoleum in 21 private rooms and two offices. We laid it down first in four rooms—private rooms—and two offices. We bought a linoleum which the dealer calls an English linoleum. It is a little over one-half inch thick. This is not the ordinary linoleum that you see in the kitchen and pantries, it is a regular carpet with a glossy finish. As explained before, we laid these in four private rooms, in our best private rooms, in the office of our chief clerk and in my office. It was laid down on plain wooden floor, cemented. It was perfect, but it showed for quite a long time the foot marks. It was of a dark green color, but it was so satisfactory that we decided to put it down in seventeen private rooms. We put it down there and through some oversight it was not cemented, it was nailed. Inside of



one year the seventeen private rooms where it was not cemented were in a fearful condition, and we had to tear the carpets out. The rooms that were cemented still are used and are wearing wonderfully well. They are scrubbed with soap and water every single day in the year. I think all our other floors in the fifty rooms, which are all maple floors, varnished, are by no means as nice, good and clean, as in these two rooms, which are in constant use, people coming in and out all day, and they are very satisfactory.

CAPT. TOWNLEY: Before asking the next question I should like to have some one answer the question propounded by Mr. Rothschild as to the sanitary effect of a linoleum floor as compared with a tile or hardwood. Dr. Howard, you are an authority.

DR. HOWARD: I cannot give you a technical answer, if that is what he wants. I can say that I was satisfied, without having my data here, before I prescribed linoleum floors for the wards, that I was prescribing something that absorbed less than wood. I was satisfied of that, but I have not my data here to show you just what that was.

CAPT. TOWNLEY: If Mr. Rothschild will go to St. Luke's Hospital and ask Mr. Clover, he will tell him all about it.

*Question 8: Please state the best treatment of hardwood floor when an oil finish or wax are not to be used?*

CAPT. TOWNLEY: Will somebody volunteer to answer that question. I will presume to answer that and say alcohol varnish. I know some one who is the best authority on this subject, but I promised I would not call on her—or him. Mr. Gill, of Germantown.

MR. GILL: I do not know just what the question is. In regard to washing floors, we do not feel that it is necessary to wash the floors more than three or four times a year, then we wash them thoroughly with lye and hot water, take all the old wax off, then we immediately start to waxing again and polish daily with a weighted brush.

CAPT. TOWNLEY: What method do you use to wax the floors?

MR. GILL: I cannot tell, but we do reduce the wax down with turpentine, making it of liquid consistency. I think that saves a great deal of time and prevents getting down on the knees to put the wax on the floor.

Question 9: *What has been your experience with a motor ambulance, first, gasoline; second, electric?*

DR. ROSS: First of all, I have had no experience at all with electric motors; we have had experience with motor ambulances, and gasoline engines. We find them very satisfactory in the climate we are located. I think the selection of an ambulance, whether motor, electric or gasoline, depends somewhat on where the hospital is located. New York has different problems to face than we have. Last winter we had a total fall of snow, between the time the winter commenced and ended, of ten feet and three inches. Many times it was heavy, many times we could not have used an electric ambulance at all, we needed more power, a power which would hold out longer than any battery. One great objection to a motor ambulance with gasoline engine is that the driver has an unlimited speed and unlimited power, and you can make up all the rules you wish to control the speed of the ambulance, yet if you are out on a back street you will find him running it at 30 to 40 miles an hour. When we first got our ambulance we had it two weeks and it was smashed up in an accident; the man thought he had the right of way over everything, and tried to smash a street car with it. We let him go. The second man tried to run through a street car, smashed the motor again, but altogether we find the motor ambulance very satisfactory. It is always ready to respond to service. We have had very little troubles with tires, and we can do rapid work and in all kinds of weather. During the warm weather this season our calls were long, it would have been impos-

sible to have cared for them with our regular supply of horses. We had no trouble with our motor ambulance. Someone who has had experience with the electric will have to answer that part of the question.

DR. FISHER: We have had one electric ambulance for ten years, and I partly donated it to Capt. Townley, and we bought three new ones. We asked to have the speed limit on our electric motor fixed at not to exceed 15 miles an hour. They generally run about 12 for our service in New York and we supply our own electricity. That service has been to us highly satisfactory; besides, it does not cost so much for a chauffeur for an electric as for a gasoline. Then, too, we have gotten rid of the smell of gasoline about the hospital. I do feel that the motor ambulance generally is a very comfortable and most important thing for a hospital to consider if it has got to keep the ambulance on the premises. We have eliminated the question of stables and horses and to just that extent helped to solve the question of supplies and things of that sort, and nuisances which are likely to result from the stables. Our ambulance will go four or five miles in the City of New York, so the limitation of speed is a good thing.

REV. DR. STEEN (Philadelphia): The Presbyterian Hospital in Philadelphia has had an electric ambulance for a little more than a year. The first year and a half, rather more than that, we had a great deal of trouble from the fact that we had no battery in reserve, and if our ambulance came in with the voltage run down we sometimes had to delay unduly in answering calls. We, two months ago, solved that difficulty to a great extent by having our old battery thoroughly overhauled and put in order; that is the condition under which we have been working the past few months and the improvement has been great. It has given in general good satisfaction. As to what the comparative expense between that and the horse ambulance is, taking

all things into consideration, I am not able to say at the present time, but I think, all things considered, the electric ambulance has not been a greater expense than the horse engine.

DR. FISHER: I hope you are not going to let the gasoline machine run its unlimited speed.

CAPT. TOWNLEY: There is a mechanical contrivance which will limit the speed of a gasoline car, lately invented. The district in which the gasoline car, of the hospital with which I am connected, runs, is in the country. We have not that great traffic that they have in the lower part of New York and we make our maximum speed 20 miles. We could not do it if we had as much traffic and as much congestion as they have in the lower part of the town.

DR. ROSS: Where is that apparatus to be obtained?

CAPT. TOWNLEY: Studebaker's.

DR. ROSS: Is it applicable to any car?

CAPT. TOWNLEY: They say so, but you will have to talk to the ambulance people about it. I really know very little about it. I wanted some means to check speed, because, as you say, you can pass all the rules you please, when they get outside (may be a joy ride), they are going 40 to 45 miles an hour. Mr. Owens will tell you how he does it. It has only been put on recently.

THE SECRETARY: I heard this morning of a case of excess speed limit. A young man had saved his earnings for nine years to buy a gasoline automobile and it burned up in seven minutes. This story illustrates one advantage, I think, the electric ambulance has over the gasoline ambulance, which may be kept in mind when one is purchasing.

CAPT. TOWNLEY: Really it is the nature of the service. There is no doubt that the gasoline car is capable of greater power, is a better hill-climber, and can do harder work than the electric. If you have your own plant you have to have more than one battery.

DR. STEEN: We, for four months, went on that plan, having our own electric supply; we did not need but the one battery, we thought, but we found we were mistaken. You can put your block in, but you cannot fill that battery up in very short time when it is run down, without injury to the battery.

A MEMBER: What battery do you use?

DR. STEEN: I cannot tell you; it is by the General Vehicle Company. It was one built by the Edison people.

A MEMBER: That you can charge at any time?

DR. STEEN: Well, we keep ours under charge, but you could not charge it very rapidly without injury, and so we found it necessary to get a second battery which would be kept ready, so that if the ambulance comes in with the voltage run down, and if there is a call to be made, it only takes a few moments to transfer from one to the other.

DR. KAVANAGH: I have been listening to a great many lectures recently on ambulances, because we have been buying one, and we have waited for the General Vehicle people, and we have discovered this, that when the old battery is used it must be practically exhausted before it is charged, while the new Edison batteries can be charged even in a few moments, and the oftener the better. But the old battery, which I think is for the most part used by the General Vehicle, must be allowed to run down from start to finish.

CAPT. TOWNLEY: Not to a point of exhaustion. You ought not to charge till you get down to 10 or 12 miles. You can do it, but you are running chances.

Question 10: *What stand does the A. H. A. take in regard to the request of local physicians to have all hospitals receiving state aid open institutions, so that each physician can treat his own patients in the hospital?* (In our town there are from 50 to 60 physicians, and it could happen that on one day 55 different physicians would have as many or more patients in the hospital.)



DR. KAVANAGH: I do not know what this Association would say about it. I only know that I do not know quite what one member would say about it. I have a great deal of sympathy with the practicing physicians in the neighborhood having some chance to take care of a certain run of patients in the hospital, but as to opening the wards, I think that would mean very great confusion and be practically impossible in order to get good service. If you start that sort of thing you get the Sage foundation after you. That is all I know about that.

Question 11: *Would not proper co-operation between Superintendents in the same town or city, meeting regularly for the purpose of discussing and obtaining good quality and reasonable prices of hospital supplies, and employing one special clerk for the purpose of obtaining and tabulating pertinent information,—be as efficacious and infinitely less expensive than the purchasing bureau now existing in New York,*

MR. O'BRIEN: I do not doubt, Mr. Chairman, but what hospital superintendents could get together and have their work done much cheaper than it has been done by the bureau in New York. I would like to state how the bureau in New York was organized. The superintendents of twelve hospitals came together and appointed six of the number as a committee who meet together as often as necessary to take care of this work. That committee found it necessary to employ more than a clerk and also found it necessary to rent office space in which to do the work. It may be true that this committee has been extravagant and that other hospital superintendents getting together can do much better, but I speak on behalf of our organization. I can name twelve private charity hospitals in this city, if they should come into the bureau at this time it would make the expenses of the bureau for the institution with which I am connected about -300, that means above the expenses of an office boy, about \$25 a month. If I can have the services



of six hospital superintendents, one capable purchasing agent who must have had considerable experience in the market, and as many stenographers as may be necessary to carry on the work, for \$25 a month to be relieved of all the care of selecting materials and being sure that I am having the right price, I think it is of great advantage to belong to the bureau.

MR. ROTHSCHILD: This is a subject that strikes home. We have the experience of the hospital standardization bureau in this city; we have also the experience of the institutions purchasing hospital supplies, two institutions of this city, of which the institution which I represent is a component part. While, if they are properly managed there might some good be effected from such organizations, yet the short experience that I have had tells me it is absolutely detrimental to the interests of the institutions concerned in it. The institutions are so varied, speaking on general lines, that there can be no generalization. The purchasing for a number of institutions so far has been more or less a failure, because it cannot be carried on unless the committee is in possession of large capital and still larger warehouse. These two things being wanting, it must become a failure. As to the proposition of our friend O'Brien, I believe that is more feasible, for the superintendents of similar institutions to come together, they can confer with each other and possibly hire a statistical clerk for the purpose of finding the best means of purchasing the different articles required, especially articles of food. I suppose that is what Mr. O'Brien is thinking most of. Am I right?

MR. O'BRIEN: Not necessarily.

MR. ROTHSCHILD: This, I think, is about the most feasible plan of co-operation between institutions, the superintendents themselves get together, exchange experiences and act accordingly, but our standardization bureau, I believe, has already been marked with failure and its offspring, the purchasing company, is fast becoming the same thing.

DR. FISHER: I want to say something about the bureau. I suppose when the Superintendent of the Montefiore Home says that standardization has proved a failure, he refers to the Hebrew Societies organization. We started this hospital bureau of standard supplies, of which Mr. O'Brien is Secretary. I happen to be a member of the Executive Committee. I believe we have started in the right direction. Whether there have been any mistakes made, or whether it has been somewhat more expensive than it might have been, those are fair questions. We are profiting by experience, but I believe the idea is a right one. It may be necessary or desirable that there should be a classification as to size; perhaps the large hospitals and the very small ones cannot work together very advantageously, possibly that has to be worked out, but if the superintendents of hospitals would only get together as an organization on this question of purchasing supplies, they would find, I am sure, as we have done, that there are a great many supplies that could be standardized and could be purchased, and arrangements made to purchase them in large quantities directly from the manufacturers. This idea of ours grew up through our Treasurer, Mr. Frost, who is the purchasing agent of the Harriman System of Railroads, spending perhaps \$100,000,000 or \$200,000,000 a year, and they developed there a standardization of supplies. They found that their various railway trains and restaurants across the country and their steamship lines up and down the Atlantic Coast and Pacific, were almost every one of them using something different. When they got together they discovered that they could standardize things, and they are perfectly satisfactory. The moment they did that they found they were able to purchase in tremendous quantities and directly from the manufacturers and at a great saving. That is what railroads have been doing; they have been trying to find out how to save money by the economical use of goods and economical buying, and that is what we are trying to do.

We admit that we have done some things that we might have done a little better, but we have been getting the experience and it is worth a great deal to me (and I know it is to a great many of our men) to be able to feel, after talking it over with our purchasing agent to leave him to transact the business, after giving certain directions. After he has looked the matter up and reported to us what he has done we feel that thing is pretty well threshed out and that we have gone to the bottom of things. We try and purchase from standard and reliable people, but I do not know of anything that we purchased that we could not go down on Second Avenue and buy a lot a little cheaper now and then. But I do not believe that vitiates the plan. I commend this proposition to any hospitals in the cities and towns around, if you can get together and standardize some of the supplies and arrange with some superintendents, or somebody who will take up the business, to make the purchases, that you will be benefited, and I think that our organization is a good one, barring some things that can be done better.

*Question 12. Should general ward patients be allowed to have their own physician if said physician be a member of the staff?. Should physicians be allowed to make a charge to ward and free-bed patients?*

CAPT. TOWNLEY: The chair has great gratification in having been able to obtain a responder to these questions in regard to ward patients being allowed their own visiting physician, I have much pleasure in presenting Mr. Ludlam.

MR. G. P. LUDLAM (New York): There has been, of course, as we all know, a certain restlessness on the part of attending physicians and surgeons over the conditions under which they render their services in a hospital, and perhaps from no other source does it emanate so much as from the lack of compensation for the services rendered. I confess that my sympathies are largely with them in all these ques-

tions, and yet back of it all there lies the question as to what is the duty to the patient in the recognition of the rights which a patient has when he becomes an inmate of a hospital. Now, as a matter of fact, every one going into any community that is governed by law must of necessity either forfeit or else consent to have temporarily suspended some rights and privileges which they enjoyed elsewhere. Hence, when a patient comes into a hospital he must of necessity accept the conditions, the rules, the laws governing in that hospital at the time of his admission, and I cannot see any real ground for changing that so far as I know which prevails pretty generally throughout hospitals in the matter of compelling ward patients to accept the service at the hands of those who are on duty at the time they enter into and become patients in the hospital. If there are any good reasons why their right to select their own physicians be recognized, I have not heard of any such reason. Of course, there is a danger on our hospital work of breaking down the personality, the individuality of the patient; that we want to avoid. We do not want to make any rules or any laws, or compel the patient to submit to any conditions that are going to break down that patient's self-respect. We do want to banish absolutely and totally, I think, from all our hospital business the word "charity" patient. It is an unfortunate thing that that term ever came into existence, and I think that we want to banish it as thoroughly as we can, but we want to try and prevent the patient in a hospital ward from thinking, imagining, believing, suspecting that he is that unfortunate thing that used to be known as a charity patient. We do not want to break down his self-respect; we do not want to allow a patient to become a "case"; we do not want to have him simply amalgamated with the mass of clinical material; we want to preserve his individuality. Now, I think that can be done without giving him the privilege which is referred to in this question, permitting him to select his own physician. I do not quite see why, in the

first place, such a right should be claimed by the patient, and if it were, I cannot see any good reason why it should be allowed. I see many reasons why it should not. In the first place, I think it would be unfair to the physician. Of course every physician becoming an attendant at a hospital must of necessity accept the conditions of service which the hospital sees fit to impose, and which he finds in existence when he enters into that service; but it is not right for a hospital to impose conditions that are unjust and unfair, simply because it has the power and authority to do it. There are certain things which cannot be done; it is not right to do them, even though one has the power to do them. So I think it will be unjust and unfair to a physician to compel him when he is off duty to return to the hospital at the demand of one individual patient who happened to come in and for some reason fancied that she or he would rather have the services of Dr. B., who is not on duty, than Dr. A., who is. I fancy doctors would be very unwilling to accept a condition of that kind. Then again, I think it would be confusing in the service of the doctor. Every doctor in charge of a ward is held responsible for the discipline in the ward. How can he be responsible for that ward if another physician is coming in and sharing that authority with him? It is just that much infraction of his responsibility and authority and he cannot be held responsible for it. In furtherance of what has already been said about allowing reputable physicians of a community to send their patients into a ward and attend them, the confusion that would result in the conduct of the ward business would be present in a smaller degree, but to some extent, if several physicians, even though they be upon the hospital staff, were allowed to send patients into a ward and visit them.

In regard to the question about the right of attending physicians and surgeons to charge a fee to ward patients, as I said in the beginning, I am thoroughly in sympathy with



this whole question. Anybody familiar with the hospital business must know that there is a great deal of gratuitous service rendered by physicians and surgeons. I think I may safely say, on the spur of the moment, without material reflection, that almost the pleasantest recollection that I have carried with me into retirement is the uniform courtesy, and prompt, whole-souled, generous responses which physicians have invariably made when I have gone to them and asked them to consider in their charges the pecuniary condition and capacity and ability of the patient about to fall under their care. I have never met with a rebuff in my life, and I can recall countless instances where physicians have been more than generous in giving their services without pay, and it is an exceedingly pleasant and gratifying memory to me as I look back over my hospital experience to recall those instances, but in spite of that, I do not think that hospital practice is a place where the physician should look for compensation for his services, that is, compensation in money. That is the one part of the hospital where the hospital expects to render its service without pay, because the nominal fee which is charged for the ward service of a hospital is so freely and generously remitted in all cases where the patient is believed to be worthy and deserving and unable to pay. That part of the hospital ought to be kept for that service and that purpose. Almost all hospitals now, without exception, have the pay department, private patient department where the service is paid for. Just a word in closing in regard to the payment of physicians. Perhaps we make a mistake when we are discussing this question in confining our thoughts about payment to the money end of the term. There are other kinds of payment, not money. There is compensation which a physician receives for his services in the hospital; there must be and it must be large, too, or he would not be so anxious to secure the position, and he would not be so tenacious of it after he has secured it; and he would not be so jealous of other people breaking into the



ranks, as we know is the case generally with members of the attending staff of a hospital; so there must be—I do not know what it is—but there must be compensation, large in degree and satisfying in character to the physician who gives so largely and fully of his services in the unpaid, that is, the unpaid money part of the hospital. Then, perhaps, we are wrong in our belief that the physician is not getting back something by way of return for services, the gratuitous services he renders, and it may not after all be such an imposition on the physician to ask him to render all these services without a money compensation, because he is getting his pay back, unquestionably in some other way. If the question were raised of making payment in a lump sum to an attending physician or surgeon at the time he finishes his term of duty, based in some way on the amount of gratuitous services to be rendered ward patients,—if that question were to come up for discussion, I do not know exactly how I should feel towards it, but I think I should approach its consideration with an unfavorable disposition towards it, but, as one of our favorite authors is likely to say, that is another story.

Question 13. *Would it be a practical proposition and meet with response from Superintendents and Boards of Trustees, for a woman (superintendent and graduate nurse) with wide experience along such lines, to enter the hospital field as a specialist in hospital organization and equipment?*

MISS LIGHTBOURNE: In my judgment I should think that it might be.

CAPT. TOWNLEY: Certainly, just as well as any man could enter.

MISS LIGHTBOURNE: I should say it could be done.

CAPT. TOWNLEY: It is just a question of the power of acquiring special knowledge, and it is not confined to mere man. Is Dr. L. T. Page present? This is rather an anomaly; I am asking the propounder of this question to reply to it himself.

Question 14. *What consideration do you give graduate nurses of other training schools or hospitals than your own when they enter as patients, either medical or surgical?*

DR. L. T. PAGE: I asked this in respect to the public hospitals. Of course, I did not include the private hospitals; I asked that for this reason: that I know some of our institutions and hospitals through New England and some through New York, do give a stated reduction, perhaps about one-third. I asked this question for this reason. I happened to be a member of a staff of a hospital; a nurse who had worked in the field of the hospital for me, after some time found it necessary to come back to the hospital for surgical treatment. I took her there, never gave it a thought but what she would receive a little consideration. I think a nurse should have a little professional consideration from hospitals. To my surprise I found she had none. That seemed very wrong to me. I took it up with the board of control, and they turned it down absolutely. I have since ascertained that in many of the hospitals in New England, nurses do receive a professional discount. I do not call it charity. When I made the appeal to the President of the Board or the Executive Committee, I put it to him in this way: "I am not asking you for charity for this girl, I do not wish it, I just want you to give the girl fair play, fair treatment." It was taken up after a little at a meeting of the Executive Committee, and they simply reiterated their rules, that no one outside of their own staff, the medical and surgical staff and the graduates of their own training school, should receive any consideration other than a layman. I think that is drawing the skirts of humanity a little close. I should like an expression. I have taken some pains to go into this and see what the different institutions of the country do; I want to find out about that, that is why I am here.

DR. WASHBURN: At the Massachusetts General Hospital we deduct one-third from the board for nurses who are not graduates of our hospital, who will go into private rooms. We do the same for physicians and the same for medical students. If any of those people, physicians, nurses or medical students, wish to go into the open ward, they can always have a free bed.

MR. L. A. GIBERSON: I should like to ask Dr. Washburn what they do with their own graduates?

DR. WASHBURN: The Alumni Association has raised \$5,000 by giving fairs, which supports a free bed. Although a free bed in all other cases means a free bed in the ward, this means a free bed in a private room.

MR. GIBERSON: If there are several nurses at the same time?

DR. WASHBURN: It would not make any difference; all our nurses would have free rooms.

MR. ZULICH: We charge the alumni nurses and graduates of our institution \$5 a week, regardless of the room they might occupy, but they are subject to the rules of the hospital. However, I believe that any hospital should take care of any graduate nurse under the same rules that they take care of their own graduate nurses. If they take care of them free, or if they charge them, they should charge them the same rate. That is my personal opinion, although we do not do that. We only receive our own nurses, our own graduates.

DR. PAGE: Do I understand then that every one of them are treated as a layman; you think they should be treated as a layman?

MR. ZULICH: That is my personal opinion. We have never treated a foreign nurse in my institution, to my knowledge.

DR. PAGE: You do not know what you would do, then.

MR. ZULICH: If we had a foreign nurse, following inclinations of my own, I would treat her the same as we treat ours.

DR. KAVANAGH: We are accustomed to treat the graduate nurses of other schools as we do the physicians not members of our staff. We allow all physicians a discount of 25 per cent., and we allow all graduate nurses of other institutions 25 per cent., if they can pay it, and if they cannot, why, we try to treat them somewhere along the point of their ability. As to our own graduate nurses, we have cared for them always in what we call semi-private accommodation, in rooms with two beds. We make no charge for them there, or for ministers and their families, or for deaconesses; we make no charge in that semi-private accommodation. According to our rules, if they insist on getting a room by themselves, then we expect that they will pay one-half, which they do not very often do.

MISS AIKENS: If the nurses themselves wish to endow a private room, what would be a fair sum to fix for endowment? I know that varies all the way from \$5,000 to \$20,000, and when nurses are working to raise a sum of \$20,000, it seems like putting quite a burden on them, and it seems as though there might be some sort of rate that nurses could possibly meet in the course of a few years and feel that they had endowed a room that was free to nurses.

DR. KAVANAGH: Our alumni association is endowing a room in our hospital. Of course there is no such thing as endowing a room anywhere for \$5,000, there is no such thing as endowing a room for \$10,000, the fact is that \$20,000 does not support any room anywhere within 100 miles, I suppose, of New York City. Nevertheless, the nominal figure is placed on some of our rooms of \$20,000 to endow a room with one bed. Our nurses have tackled that room. We did not expect when they began it that they were going to

finish it, but nevertheless they went at the business, and they have paid in \$5,000, and by the time they pay in the next \$5,000, I think the other \$10,000 will somehow be put out of commission. That is, they are doing their best to endow that room, and we propose to help them through. Then they will have a room for themselves.

Question 15. *We have numerous complaints about patients being awakened too early in the morning. Is it possible, or desirable, to have a fixed hour before which night nurses may not be allowed to awaken patients in the morning? If so, what hour is best?*

MISS KEITH: I have heard that complaint. I think, before. In our hospital, the patients in the ward, where there has been but one night nurse on duty during the night, are allowed to sleep as late as possible. The night nurse is required to see that their faces and hands are washed before she goes off duty at 7 o'clock in the morning. That does necessitate their being awakened sometimes about 6 o'clock, or not long after six. On our more expensive private rooms, if they are in their own homes in the habit of sleeping later, their toilet is left entirely to the day nurse, who comes on later, but the class of patients who occupy public wards are, as a rule, in the habit of waking and rising as early as six, and in our own case we have not had that complaint from them.

Question 16. *Should nurses in training be paid? Is it easier to keep up a full corps of nurses by giving them allowance? What amount is ordinarily given?*

MISS AIKENS: I do not believe the first question, "Should nurses in training be paid?" will be settled in our generation. I believe it is like a great many other nursing questions that we are struggling with at the present time, they have to go through a process of evolution and settle themselves, and I do not believe this Association or any other association could ever give a satisfactory answer to that



question. Institutions vary so greatly, and our conditions vary so greatly, that we simply have to meet the problems patiently as they arise, as the physician does his symptoms. I was trained in a hospital which gave an allowance, and I remember that allowance was quite a satisfaction to me. I had gone into training rather against the wishes of my parents, as a great many girls had done. I awfully hated to send home for money, and it was a great deal more gratification to spend that money myself to pay for my own uniforms and books, than to have the uniforms and books given to me, and I think there are a great many other girls similarly situated.

As to the second, "Is it easier to keep up a full corps of nurses by giving them allowance?" I think unquestionably it is. I know of an institution of about 300 beds which a few years ago decided on a change of policy and decided they would abolish the allowance. It proved so disastrous to their training school that they did not recover from it for a couple of years; the ranks became so depleted, the patients were neglected and the whole institution got a bad reputation for neglect. If I remember correctly, the superintendent of nurses told me that they did not get one application in six months, so they never put the rule into operation. She told me at that time she was running with 35 less nurses than her regular staff, and trying to struggle with the problems as they arose; so I think that any institution that would be considering at this particular period at which we live abolishing the allowance after they had been allowing it, would have considerable difficulty. I think a new school starting would find it much easier to give an allowance. Where paid instructors are allowed and where pupils are helped through a period of preliminary training, superintendents feel that they should not pay pupils an allowance in addition to that, and I sympathize with the superintendents in that position, and yet those conditions do not prevail in hospitals in general as much as they should.



So far as the rate of the allowance is concerned, my observation is that it varies anywhere from about \$6 to perhaps a maximum of \$15.

Question 17. *Is it customary when a special nurse is called to a case in the hospital, to provide another special nurse to relieve her, or is the patient expected to be satisfied with the regular divided attention given by general nurses?*

DR. KAVANAGH: It is our custom that she is to be served by the regular staff on the floor. I think that covers my experience with it.

Question 19. *How long is it customary for special nurses to be relieved in the twenty-four hours?*

DR. BABCOCK: I am not able to answer that question for everybody, but in answering for ourselves, we make a practice of relieving our special nurses in light cases, I mean those cases where the nurse can get a reasonable amount of sleep during the night, where in most cases their sleep is uninterrupted. In heavy cases, where the nurse is up much during the night, the relief is twelve hours. I believe the custom, particularly in the East, is growing, to extend that relief, and Dr. Ross, if he were present, would tell you that in Buffalo General Hospital they have made it a rule that the relief in all cases be twelve hours.

CAPT. TOWNLEY: I endeavored quite a while to get somebody to respond to this question, but they all said I would have to go to a lawyer about it.

Question 19. *In inquiring of several States their requirements for the registration of nurses, we note that from about one-third of those written to, the requirement of a "Chartered School," and from perhaps another third, "Registered School." Now, what do they mean by the terms "Chartered" and "Registered"? Our best lawyers say that, since the passing of the new Corporation Bill, there is no such thing as a chartered school, in any State. Please discuss the significance of the two words.*

CAPT. TOWNLEY: I don't know who asked this question; I should like to refer him to some lawyer, or legal dictionary of signification of words. Will somebody volunteer to give him the difference in the signification?

Question 20. *Some few States (Georgia, Virginia, etc.,) object to a nurse, in training, having the practical experience of outside nursing during such training. What are the objections to a nurse's doing outside work while in training, when such work is under the immediate supervision of the management of the hospital in which she is taking her training?*

CAPT. TOWNLEY: Miss Anderson, I believe, is not in. Miss Keith, will you answer this?

MISS KEITH: I cannot, Mr. Chairman. I have never been connected with an institution which did outside nursing, and I am not prepared with an arguement on that score.

Question 21. *What kind of reception is given to nurses from other hospitals coming there for duty? Also, what is done with regard to former graduates, either visiting or on duty in their own hospitals, after an indefinite absence?*

CAPT. TOWNLEY: If somebody does not respond promptly, we will take up the next.

Question 22. *In public hospitals where X-Ray, minor operations performed, and other treatments given in the dispensary during dispensary hours, who collects the fees when patients are able to pay, and how is the disposition made between the hospital and physician, or should the hospital receive all. Who decides the amount the patient is to pay, the superintendent or physician?*

DR. KAVANAGH: In my hospital the superintendent does. That is handled the same as other bills and collections.

MR. PARKE: In the X-Ray department we divide the fees. These are regulated by the hospital, providing a remuneration for that special work.

DR. STEEN: In the Presbyterian it is the rule to divide the fees for X-Ray work for private room patients, but the same man does free work in the wards.

DR. KAVANAGH: That is the rule so far as private patients go, and in the wards we get a fee of about \$2; then the division is also made. That means a little something to be allowed in individual cases.

CAPT. TOWNLEY: When the radiographer is paid for his services, the hospital takes all the fees and pays him a liberal compensation.

Question 23. *Are physician's fees charged to patients for operations or treatments, who can only pay \$1.00 a day to the hospital?*

CAPT. TOWNLEY: I think that was included in a question that has been answered.

Question 24. *Do hospital boards have a maximum fee for physicians when the patient can only pay \$10 or \$15 in a small ward or room?*

CAPT. TOWNLEY: That is the same thing.

Question 25. *How long is it necessary to keep internes' histories and nurses' records of discharged patients?*

CAPT. TOWNLEY: Why, they never should be destroyed, is my opinion. Does anybody have a different opinion from that?

MR. PARKE: If never, where are you going to keep them?

CAPT. TOWNLEY: You can always store that sort of thing. As long as litigation is possible and records are necessary to establish a person's right to an inheritance, or for any legal cause, then all records pertaining to that patient in a hospital should be available, certainly within a reasonable lifetime, three score years and ten.

Question 26. *What is the average salary paid to supervising nurses (of wards, private floors and maternity wards)?*

CAPT. TOWNLEY: It varies with the number of hospitals, I should say. Will some one answer the average price? Is there any average?

MR. PARKE: I think there was a schedule got up two or three years ago; it is in our records now, of three years ago.

Question 27. *How provide the nursery in a hospital of thirty beds (medical and surgical)?*

CAPT. TOWNLEY: I am glad these questions are anonymous, because if I do not get a reply I will omit some of these.

Question 28. *Should a hospital be expected to give a reduction in rates to a dentist holding an M.D. degree, but not practicing medicine?*

DR. PAGE: I always do give consideration to the dentist myself; I do not know why the hospital should not, if he needs it. I think that is altogether different from the nurse's standpoint. The nurse is a part of the medical profession, one of our employees.

Question 29. *Is there a hospital anywhere which will give one to three months operating room training to graduates of a small hospital when such graduates are wanted as operating room superintendents?*

DR. E. B. SMITH: We have done that in one or two instances, where the nurse is a graduate nurse with proper credentials, who wanted operating room work. Miss Rindlaub, of the South Side Hospital, Pittsburg, does that.

CAPT. TOWNLEY: Will Miss McCullough answer this question:

Question 30. *How store milk for a hospital of 100 beds?*

MISS MCCULLOUGH: I think all hospitals, when it is possible should have their milk brought to them in bottles. In a hospital of 100 beds it seems to be a question of what to do with so many bottles. I have in mind a little scheme

that I may be able to patent before long, if I get the opportunity, in which we can put the bottles in racks in a zinc arrangement and have these baskets to go up and down on a cog wheel arrangement. In it we can put any number of bottles and it can go up the side to the ceiling, and as each basket is drawn up the thing will go around and around. I am sure we could store milk for 300 beds in that way; it would not take up very much room, and in that machine we would have some arrangement that would keep it at the proper temperature. That would do away with emptying the milk from the large cylinders which are brought to us by the railroads. It could be carried to the ward and kept in bottles until it is used. Much milk as it is poured out receives infection. In this way we can keep the milk in a good condition. I am sure that there is very little expense in a hospital having a refrigerator plant; even with only 50 pounds of ice a day or with an ammonia coil or a CO<sub>2</sub> coil. I am safe to say, 200 quarts of milk could be stored, and that milk could be taken in the bottle to the ward and placed in the refrigerator, whatever it may be and emptied from the bottle into the glass of the patient. It seems to me very plausible and very possible for that to be done.

CAPT. TOWNLEY: That closes the questions, and before I close this question box session, the President has something to say.

THE PRESIDENT: I would ask all the members present to be here promptly at 3.30 this afternoon. We are going to have two good papers, the election of officers and decision as to time and place of next meeting.

Adjourned until 2 p.m.

FRIDAY, SEPTEMBER 22—2.30 P.M.

REPORT OF COMMITTEE ON CONSTITUTION  
AND BY-LAWS.

The report of the Committee on Constitution and By-laws, as presented at the previous sessions, was read.

PRESIDENT: What is the pleasure of the Association with reference to this proposed amendment to the by-laws?

DR. GOLDWATER: I should like to ask what the intention is with regard to the permanent chairman of exhibits? It says how the chairman is to be appointed, but not how he is to be disposed of in case the Association wishes it.

PRESIDENT: By inserting the word "annual," we might have an opportunity of getting rid of any permanent chairman. The idea of the word "permanent" was, to arrange so that one person carry on this work for two or three years or more successively, otherwise the exhibit may not amount to very much.

DR. GOLDWATER: The word "annual" does not convey the meaning of being permanent. If there is to be any special designation it seems to me it ought to be a perfectly clear one.

PRESIDENT: Will you suggest an amendment?

DR. GOLDWATER: I suggested one yesterday; the committee did not adopt it. I believe it would leave us in the air if that amendment is adopted in its present form, because the intent is not clear.

PRESIDENT: You suggest striking out the word "permanent"?

DR. GOLDWATER: My suggestion to the committee on Constitution yesterday was that arrangement should be made for the appointment of a permanent chairman of the committee, to serve for a period of two or three years at a time. I think that would be easier.



PRESIDENT: You make an amendment then, to have that read, to serve two or three years, or any given number of years?

DR. GOLDWATER: Yes, I proposed that amendment.

PRESIDENT: Will you read the by-law as amended?

MR. MOTT: "The Committee on Commercial Exhibits shall arrange annually for an exhibit of non-commercial hospital appliances. The chairman of this committee shall be an officer of the Association, to be appointed by the president for a period of two years, and shall be allowed not to exceed the sum of \$250 per annum to defray expenses."

DR. KAVANAGH: Why put in the expression, "two years"? Can this chairman as he goes out appoint somebody for two or three years? Can the chairman that comes in after him appoint anybody for two or three years. They will simply make their appointment from year to year. It seems to me that it is best to leave it just as it is, without the "permanent" and without "two or three years." Let the appointment be made every year, as the president is elected each year.

A MEMBER: Will there be a report on the permanent secretaryship? I think we will be better informed on that proposition when they report.

PRESIDENT: I will ask Dr. Goldwater if there is anything in his report to influence this. The committee is only reporting progress; this is a matter to be decided now.

MR. BORDEN: Is that suggested as an amendment to the by-laws?

PRESIDENT: This is a new section under "By-laws."

MR. BORDEN: Why is it necessary to insert a thing like that among the by-laws? Why cannot the Association authorize the expenditure of that money without having it come under the head of by-laws?

PRESIDENT: Article IV. of our constitution gives a list of all standing committees of the Association; this adds a new committee to that list. Is there any further discussion? Do I hear that amendment seconded? (Seconded by Dr. Brown.)

PRESIDENT: Motion has been made and seconded that this by-law be adopted. All in favor of this by-law please rise.

Motion carried; ayes 23, noes 6.

MR. MOTT: (Reads paragraph on Secretary's Salary) The allowance for the work of your secretary is now \$360 per year. This was a sum appropriated some years ago. The Association has since greatly increased in numbers and the work of the secretary has expanded in proportion. It is the opinion of your committee that the important work of this officer should not be handicapped by a limitation of funds, and after consideration of this matter with your former secretary, Dr. Babcock, the following recommendation is proposed: That the concluding sentence of Sec. 3, Art. 4, read as follows: That the secretary shall be allowed a sum not to exceed \$600, to defray the cost of clerical assistance.

Seconded by Dr. Kavanagh.

PRESIDENT: Before asking for a discussion I should like to say a word or two. I am no longer secretary of the Association, but acted as your secretary for three years, and I appreciate very fully the amount of work that the secretary is undertaking. When that allowance was made, the membership of the Association was less than one-half of what it is now, and the work has increased to such an extent that it is impossible to get out the transactions, handle the membership list and do the corresponding for the amount that has been allowed. The Association has \$2,000 in the treasurer's hands, and we can well afford to pay our secretary for the actual work that he does. I should like to hear any comments or discussion.

MR. BORDEN: I make the same objection that I made to the previous proposition. It is perfectly proper from year to year to determine what sums shall be appropriated for certain purposes without making it a fixed sum in the by-laws. I am thoroughly in favor of having an adequate appropriation for the Secretary, but it seems to me that can be done, and done in a more businesslike way than by setting it into the by-laws.

PRESIDENT: If we made an appropriation by resolution, we would have to amend Section 3 of the By-laws, otherwise we would have a by-law calling, as we have now, for a definite expenditure and we would by resolution be paying another sum.

MR. BORDEN: I think it would be wise to amend the By-laws.

MR. LUDLAM: Do I understand the expense of issuing the annual report and the postage all comes out of this appropriation made to the Secretary?

PRESIDENT: No, this section reads, "shall be allowed the sum of \$360 per annum to defray cost of clerical assistance."

MR. LUDLAM: Does that include the cost of printing and mailing?

PRESIDENT: No, no. Is there any further discussion? This motion has been seconded. Are you ready for the question:

DR. MORRILL: I expect it is too late now, but we seem to be getting into trouble over the method of handling our finances. I think we ought to have a Budget Committee that can go over these questions and then we can take them all out of our by-laws and leave them alone, as we properly should. Let the Budget Committee make its recommendations, and they could handle the whole problem, instead of going over it piecemeal, as we have it in the present system.

PRESIDENT: All in favor of this resolution, please rise.

Resolution carried; ayes 25, noes 0.

DR. KAVANAGH: The fact that we voted does not mean that we approve of this thing just as it is. I think there is a great deal in the suggestion of a Budget Committee, but there is no time to attend to this at the close of this convention, and therefore we have voted for the resolution as presented, so that the officer may have the necessary fund during the year. But I think next year it would be well at the opening conference to appoint a committee on by-laws to take up this matter and see if it can be improved.

PRESIDENT: We only expect this allowance to be a temporary allowance; we expect within a year or two to have a report that will permit us to have a secretary that will be permanent. There has been some criticism of the by-laws. It seems to me that Dr. Kavanagh's suggestion that the Association authorize the appointment of a committee for revision of the by-laws as a whole would mean quite an undertaking. We should have a committee who would have a year, or the time between conventions, to go over that matter thoroughly.

DR. MORRILL: If you will make that as a motion, I will be glad to second it, with the suggestion that they particularly study the question of a Budget Committee to handle all this financial part of it.

DR. KAVANAGH: Mr. Chairman, I am glad to second the motion.

PRESIDENT: That motion is for the appointment by the incoming President of a committee for a revision of the Constitution and By-laws.

DR. MORRILL: It is the By-laws that we have been having the trouble with.

THE SECRETARY: Might I inquire if the appointment of our regular Committee on Constitution and By-laws might not accomplish this work?

DR. GOLDWATER: The regular Committee on Constitution and By-laws has certain specific duties, but some three years ago, when the Association seemed to be constantly in hot water over matters of this sort, due to the expanding nature of the Association, there was inserted in the Constitution the provision for the appointment of a committee on the permanent development of the Association and to present to the Association such measures as would keep the constitution and by-laws up to date. This year, for reasons best known to the President, such committee was not appointed. It seems to me no special committee is needed, because the constitution provides for the appointment of that committee from year to year.

PRESIDENT: It might be wise to put off the revision of Constitution and By-laws another year, for the reason that the Committee on Permanent Secretaryship and Information may bring in a full report and make definite recommendations. If we revise the Constitution and By-laws this year, they will have to be revised again to make provisions for the recommendations of this special committee at the time they make their report. I should like to hear from the committee on that.

DR. STEEN: I suggest that we lay this matter on the table, to be taken up next year. (Seconded.)

PRESIDENT: The original motion was to appoint a special committee for the revision of the Constitution and By-laws. Motion to lay on the table is seconded.

Motion to table was put to vote and carried.

## REPORT OF COMMITTEE ON COMMERCIAL EXHIBITS.

DR. KAVANAGH: The Committee found it difficult to agree as to what was the wisest thing to recommend. We are agreed perfectly between each other, we had no trouble on that score, but we were anxious to bring in a resolution that would be looked upon with favor by the entire body, or a large part of the body. We found that some of the older members of the Association that had been familiar with its history from the beginning until now have not looked altogether with favor upon making definite arrangements with supply houses to make their exhibits. We found also there was quite a demand on the part of many that live long distances from where the supplies may be more readily reached, to have such an exhibit. In our investigations, although we did not reach a very large number, we found these two feelings or desires very marked. The result is that we have brought in two reports, and we have all agreed to each of the reports. It is not a minority report and majority report, but we resolved to give the Association an opportunity to decide this matter for themselves. Now, let me read the reports.

Your Committee to whom was referred the resolution in regard to arranging with hospital supply companies for exhibition of their supplies at the seat of our annual conference, beg leave to report:

First.—We recognize that a display of hospital supplies near or at the seat of our annual conference is exceedingly valuable to many of our members and should be encouraged.

Second.—We would recommend that the Committee on Local Arrangements in selecting the hotel or other place of meeting, keep in mind the desirability of having close at hand a hall or rooms for exhibition purposes, and to co-operate with the representatives of supply houses in regard to this matter.



Third.—We question the wisdom of this Association assuming the responsibility involved in receiving pay for exhibition sites, and, therefore, do not recommend this proposition.

Your Committee to whom was referred the resolution in regard to arranging with hospital supply companies for exhibition of their supplies at the seat of our annual conference, beg leave to report:

First.—We recognize that a display of hospital supplies near or at the seat of our annual conference is exceedingly valuable to many of our members and should be encouraged.

Second.—We would recommend that the Committee on Local arrangements in selecting the hotel or other place for meeting, keep in mind the desirability of having close at hand a hall or rooms for exhibition purposes.

Third.—While we are not in favor of entering into business arrangements with the various supply houses for financial gain, nevertheless, the Committee on local arrangements is authorized to make such charges as will guarantee the actual expense of the hall or rooms thus used.

Further, they are empowered to assign positions to the various houses displaying goods and make such rules and regulations governing the exhibit as they deem necessary.

PRESIDENT: You have heard the dual report read; what is your pleasure?

DR. FISHER: I feel like seconding the motion that it is very desirable to have exhibits. Many of the members from a long distance, possibly are located away from the big centres where the great houses are for the sale and distribution of hospital equipment, and I do not think it is the duty of anybody here to encourage an exhibit nearby where we hold our meetings. I do not think we shall have to try very hard to induce the manufacturers to make an exhibit; I think

they want to come to us, it is a straight matter of business with them. I do think, however, that if we as an organization attempt, through our committees, to decide which exhibits shall be placed—well, I do not want to be on that committee.

MR. COSGRAVE: I do not think that those of you living in New York and other large centres where you are in close touch with the supply houses, will properly appreciate the value of such an exhibition to those that are not so fortunately situated, and I for one would be glad to see such an exhibit. It is not necessary for the Association to endorse anything. The exhibitors would be charged just enough to pay the expenses of the hall. I will agree with the second report.

DR. MORRILL: There is another phase to it. A great deal of the opposition to a commercial exhibit has been on account of certain abuses which crept in, and I think the most efficient way to prevent those abuses creeping in again is to take up this second proposition. Then we will have it under absolute control of the Association. If we sanction it and do not take control of it, we will be responsible. On the other hand, if we sanction and take control, we will have a greater opportunity for preventing those abuses.

DR. WAYNE SMITH: I personally cannot see what chance we have of preventing such abuses if there is a committee to handle an exhibit any more than at present. Certainly, the hotel where the convention is held would rent rooms to any commercial house desiring to exhibit. This committee might select one room in which to hold the exhibit of which the committee approved, but we certainly could not control an exhibit in some other part of the house, which would allow the same abuses as are possible under the present system. I certainly agree with all that has been said, that a commercial exhibit is possibly a desirable thing, it may

be very helpful to many, but I cannot see that we are encouraging a commercial exhibit any more by charging them for it, than we are at present by not charging them for it. My feeling is that I should be opposed to this Association accepting any financial responsibility whatever.

PRESIDENT: The second resolution reads, I believe, that the Committee on Exhibits shall adopt such rules as they deem necessary. I would say to one point in Dr. Smith's observation that I hardly think that any hotel that we might meet in are going to permit commercial houses to bring in heavy exhibits, for instance, such as the sterilizer houses, or other equipment houses would wish to exhibit. I think this committee, judging from their resolution, recognizes that, and mentions a hall outside of the meeting place. As the resolution stands, it seems to me it is simply a question between them as to whether the Association shall control the exhibit or not.

DR. GOLDWATER: Move the adoption of the committee's report as it stands.

PRESIDENT: Which one?

DR. GOLDWATER: Only one has been presented so far.

DR. KAVANAGH: Let me say this for the second report. The committee is agreed in presenting it, because we thought, as I said a few moments ago, that we ought to get the whole thing before you. But here is one of the reasons—one of the members of this Association who has come a great deal more than a thousand miles to attend this conference told some of us that he has been present at every session when it was possible to be present, but a great deal of his time has been spent in visiting supply houses here in the city, and he would be compelled to stay over two or three days in order to conduct his investigation. He was most enthusiastic in regard to this. He said, "It would be worth everything to us that have come a long distance if there were a supply room somewhere with all the goods, or practically

all the goods that we need to look at as hospital superintendents just after dinner or before dinner." One of our superintendents, a lady from the other part of the State, said, "I want to be present this afternoon, but I cannot be, because I must visit some supply houses in the city." Those of us that are living here do not appreciate what it means to those that are living a long distance from here to have the opportunity right at hand when they come to the convention. Our medical associations do this thing; they do it on a scale that we do not dream of. They made through their exhibits enough money to carry their whole conference through, I am told by some of our medical men here. We do not want to make one dollar out of it, but we want those who bring their articles for exhibition to pay the actual expenses. There you have both sides of the question.

Dr. Goldwater's motion, that Report No. 1 be adopted, was seconded.

MR. PARKE: I move as an amendment that No. 2 be adopted. The only trouble there seems to be some abuses that many of us do not understand. I have heard nothing as to what the abuses were. I think it would be a distinct advantage to some of those coming from little places like Montreal to have the exhibits concentrated. Here are two Canadians, one from Winnipeg, one from Montreal. Our time is limited to see these things. The things we wanted to see could have been easily shown in a room close by, and we could have gone to the theatre and not wasted our time trotting all over the city. I move that the second report be adopted. (Seconded.)

THE SECRETARY: There are two points I should like to speak on. One is the difficulty of controlling the exhibit. For several years I was secretary of the Ontario Medical Association in Canada, and also officially connected with the Dominion Medical Association. Those associations have had exhibits, and I believe they, like the American Asso-

ciation, realize a certain amount of income from these exhibits, just how much I do not know, but our meetings usually were held in some educational institution, where we were given complete control of the premises. We had a local committee of arrangements which had the power of regulating these exhibits, arranging where they should go, and advising and saying who should exhibit and who should not exhibit. I would think the matter of an exhibition could be managed more easily in an educational institution or some other place, rather than in a hotel. I never heard of any particular abuses arising in Canada from holding these exhibits.

Report No. 2 was read and adopted by a rising vote; ayes 54, noes 18.

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REPORT OF COMMITTEE ON CENTRAL BUREAU  
AND PERMANENT SECRETARYSHIP, READ  
BY DR. GOLDWATER.

On September 22nd, 1910, this Association resolved "that a permanent Secretaryship and Bureau of Hospital Information be established on or before January 1st, 1914," and the undersigned were named as a Committee to formulate a plan for carrying out the purposes of the resolution.

Inasmuch as steps are now being taken to establish a Government Bureau of Hospital Information at Washington, which Bureau, if established, will in part accomplish the object of the resolution of September 22nd, 1910, the Committee on Permanent Secretaryship and Bureau of Hospital Information deems it inadvisable to formulate a scheme for the Association's permanent bureau at this time.

The Committee therefore presents this memorandum as a report of progress:

(Signed),

H. M. HURD,

W. P. MORRILL,

P. E. TRUESDALE,

S. S. GOLDWATER, *Chairman*.

DR. MORRILL: This idea occurred at a time when it was pretty dubious whether the Association could finance a bureau that would be of any great value, and in view of the fact that the Public Health Service is apparently in a fair way to become our Department of Public Health, it was thought that this would be a proper place for it. If it did go into Government service we could hope far more from it than anything private. I took the matter up with Dr. Wyman, and he has had it under consideration for some nine or ten months. Dr. Goldwater furnished me with letters from a dozen or so superintendents that heartily approved of the proposition. I think this was what convinced



a certain general and ultimately the Secretary of the Treasury that there was a real need. I simply wish to read the letter received since I came here from the Surgeon-General and approved by the Secretary of the Treasury, which gives their stand on the question.

TREASURY DEPARTMENT.

WASHINGTON.

Sept. 13th, 1911.

DR. W. P. MORRILL,

Committee on Bureau of Hospital Administration,  
American Hospital Association,  
Murray Hill Hotel, New York City .

DEAR DOCTOR,—

Referring to the personal interviews with you and the correspondence which you have submitted to me from members of your Association and others relative to the possibility of the Bureau of Public Health and Marine Hospital Service becoming a repository for plans and specifications for hospitals and dispensaries, national, state, municipal and private, both of this and other countries, and collections of data relative to hospital equipment and management, I have to state as follows:—

The great importance of this feature of your association is recognized. The extent of hospital construction, the vast amount of hospital work being continuously conducted in this country, the capital invested and the important relation of these institutions to the public health, all contribute to make the plan as outlined by you appear to be one of great value and one in which this Bureau might well participate. For the Bureau, however, to take part in the effective manner which would be essential and to place the matter on a firm foundation, the authority of Congress would be necessary.

The great interest shown in this matter as evidenced in the letters which you have shown me from Professor Wm. H. Welch and Dr. Henry M. Hurd, of Johns Hopkins Hospital; Dr. Washburn, of the Massachusetts General Hospital; Doctors Goldwater, Howell and Clover, of the Mount Sinai, Presbyterian and St. Luke's Hospitals, and from the President of your Association, Dr. Babcock, and others, and the value to the Government not only of the material collected, but of the relation which would be thus established between the Bureau of Public Health and Marine Hospital Service and these health agencies of the United States, would seem to be sufficient reason for Congress giving the matter favorable consideration.

I therefore transmit the draft of a proposed bill which contains in general the provision that would be necessary to be included in legislation. While the terms of this bill appear to cover what is believed to be desired, it is, of course, possible that some amendments or additions not now thought of might later appear to be advisable. So that so far as the Bureau and Department are concerned it should be understood that the general idea as expressed in the enclosure is approved; but any amendments or additions thereto would necessarily require careful consideration and the Bureau would be glad to confer with a committee or a representative from your Association regarding the matter.

Respectfully yours,

(Signed) WALTER WYMAN,

*Surgeon-General.*

Approved:

FRANKLIN McVEAGH,

*Secretary.*

1 Enclosure.

COPY.

## DRAFT OF BILL.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the Public Health and Marine Hospital Service is hereby authorized to collect and receive, and to classify and maintain, in such a manner as may be made accessible to State and Municipal authorities and other hospital administrators, plans of hospital or dispensary buildings, descriptive matter relating to their equipment, their rules and regulations, periodical and other reports of individual institutions, reports of committees engaged in the investigation of local and other special hospital problems, and other matters and medical literature relating to hospitals, sanitoriums, asylums, homes for convalescents, dispensaries and nursing associations, and to convey the information thus obtained to said national, state and municipal hospital authorities and other hospital administrators, under such rules and regulations as shall be promulgated by the Secretary of the Treasury.

And for this purpose the Secretary of the Treasury is authorized to submit annual estimates for such clerical help as may be necessary.

## TELEGRAM.

Washington, D.C.

To Surgeon Austin or First Assistant:

Secretary Treasury writes me has approved and forwarded my letter to Dr. Morrill. Secretary in his letter to me says "I very heartily approve of the plan and hope that it will be pressed to a favorable conclusion. Telephone this to Austin if away from Hospital."

(Sgd.) WYMAN.

By Phone:

Received 2.20 p.m.

DR. MORRILL: To put the matter on a definite basis, I have prepared a resolution, and with the advice of Dr. Goldwater and Dr. Hurd, I will offer it.

Believing that the close association between hospitals, sanatoria, boards of health, and other agencies for the care of the sick, and the Public Health and Marine Hospital Service contemplated by the establishment in that service of a Bureau of Hospital Information, could not fail to greatly promote the protection of the public health, both by interchange and dissemination of information on current health problems and by the promotion of increased efficiency in institutional administration, this Association is heartily in favor of the proposal to establish such a bureau as outlined in the letter of Surgeon-General Walter Wyman and approved by the Honorable Franklin McVeagh, Secretary of the Treasury; therefore, be it

RESOLVED, that the Committee on Permanent Secretaryship and Bureau of Hospital Information is hereby empowered to represent the Association in the matter, and is instructed to actively co-operate in securing the necessary legislation.

On motion of Mr. Souder, the resolution was adopted as read.

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REPORT OF COMMITTEE ON HOSPITAL EFFICIENCY, HOSPITAL FINANCE AND ECONOMICS OF ADMINISTRATION.

BY REV. A. S. KAVANAGH, D.D.,

*Superintendent of The Methodist Episcopal Hospital,  
Brooklyn, New York City.*

Article 2 of the Constitution of the Hospital Association reads: "The object of this Association shall be the promotion of economy and efficiency in Hospital management."

The program of this and previous conferences has been built around economy and efficiency. "The Foundation of Hospital Efficiency" is one of the specific objects treated at this conference, while all the papers and addresses have discussed some phase of economy and efficiency. I am quite sure it would be difficult to find a more exact definition of efficiency than that which Dr. Chas. P. Emerson gives in his article in "Hospital Management," when he says: "Size is a poor standard by which to judge a hospital. The only correct standard would be that of efficiency in giving each patient the individual care which his case requires."

It is my duty now, by appointment of our President, to survey as far as possible the whole field and make such suggestions as I may deem wise in regard to economy and efficiency. I cannot claim any special fitness for this task, but "such as I have" it is yours for the work sake.

As I began the task assigned me I was very soon impressed by the largeness of my subject, and wished for a broader and more exact knowledge of the interests involved. The hospitals embraced in the membership of this organization are suggestive of the wide field which we must consider. Here are general hospitals for medical and surgical diseases; hospitals for throat and nose; for eye and ear; orthopedic; contagious diseases; city hospitals; and private hospitals.

Some of the particularly noteworthy movements which perhaps are worthy of special mention are the battle against the white plague, and the increasing provision which is being made for those thus afflicted. The movement on foot at Bellevue for the training of midwives. The growth of Social Service work.

Psychopathic clinics are now conducted in connection with the Long Island State Hospital, which makes it possible for a patient to secure the best advice before becoming actually insane. Dr. Doran says that if these clinics had been started long ago thousands of cases of insanity might have been prevented. In Syracuse the City Council has established a Psychopathic Hospital of seven beds for treatment of incipient cases.

New York State has authorized work for inebriates, and the mayor of New York City has appointed a commission to consider this problem.

We must also note with satisfaction the increasing interest that is being taken in the welfare of babies. Much of this is being done in connection with our general hospitals, the greater part by other organizations, or by private enterprise. Perhaps it will not be inappropriate in this connection to mention the work of the Floating Hospitals of the St. John's Guild, N.Y., the new Seaside Hospital, the Boston Floating Hospital, and the hospital work conducted by the New York Association for Improving the Condition of the Poor.

In my judgment, there is scarcely any line of work that is worthy of more serious consideration than that of crippled children. I wish to give emphasis to this work by a quotation from a letter received from Miss C. A. Aikens. She writes: "I would think worthy of note the establishment in Minnesota and Massachusetts state hospitals for crippled children, thus making it possible for every crippled child to be put into the best condition for life, however poor he



may be. New York led the way some years ago, and Pennsylvania and Maryland are pretty well provided for, but there is a very great need that many other states should deal as generously with the crippled child as with the deaf and dumb, or blind child. You cannot realize this need if you have not come up against it as I did in Des Moines where we had not an orthopedic surgeon in the state, and where, if expert work was to be done, a surgeon had to be brought from Chicago at great cost."

Perhaps the finest achievement of the year has been the splendid and successful fight of Dr. A. H. Doty and his assistants against cholera, which a few months ago threatened this city. Every citizen has read this story with a sense of pride; and also with a sense of shame, when they remember the humiliating investigation to which the doctor was subjected in his hour of triumph. Investigations there must be for the public good, but reckless, semi-political attacks upon the good name of a public servant should not be tolerated.

Now this brief survey indicates the vastness of the hospital and kindred fields. The Superintendent should, in a measure at least, be conversant with the entire field. This leads me to emphasize the importance of the literature of the year as an aid to efficiency.

The time was when, according to the acknowledgement of our most experienced Superintendents, they had to blunder along for years while mastering the numerous duties of their offices. While that day has not quite passed for many of us, there is not the same excuse now that there once was for this condition of things.

One book has come from the press during the past year which is indispensable for the young superintendent, and not altogether devoid of profit for the oldest. I refer to "Hospital Management" brought out under the direction of

that suggestive and sane writer upon all hospital matters, Miss Charlotte A. Aikens, and published by W. B. Saunders & Co. The subjects treated, and the names of the writers, suggest the value of the book.

"The American Hospital Field" is treated by Dr. Chas. P. Emerson; "The Board of Managers and their Responsibilities," by E. S. Gilmore; "The Superintendent," by Geo. P. Ludlum; "The Medical Service of a Hospital," by Dr. Henry M. Hurd; etc.

Then there are other indispensable publications such as "The International Hospital Record;" "The Trained Nurse and Hospital Review;" and "The Canadian Nurse and Hospital Review;" while the annual proceedings of the American Hospital Association cover practically every phase of hospital work.

Scarcely second to these would I place carefully written reports. I do not mean reports which are chiefly statistical tables, containing only the diseases that the "flesh is heir to." I mean reports which in addition to the various tables give the actual history of the year,—the improvements; the work done; administration, medical, surgical and nursing.

I am glad to acknowledge my indebtedness to such reports in trying to form and realize correct ideals in my own work.

In the next place I wish to say there can be no economy or efficiency worth while without careful and exact business methods. It is well known that the public is sceptical of the business methods of charitable institutions, both public and private.

When Hon. Bird S. Coler became the first comptroller of the united cities which form Greater New York, he changed the unbusinesslike graft cultivating method of giving lump sums to private institutions, to the per capita meth-

od,—a change which put some institutions out of commission at once. To-day the city authorities are scrutinizing every dollar expended for charitable purposes. To this no honorable institution should object.

As to business methods, our private institutions, if possible, should be in advance, rather than behind, public institutions. They are supported by the voluntary gifts of the public, and must by their business method, as well as scientific work, command the respect and confidence of the public.

It was this ambition that led this organization some few years ago to adopt the uniform method of accounting, which originated with four of our largest hospitals in this city. Now the best thing about this method of accounting is not that it aids one in making a comparison between hospitals engaged in the same sort of work, or between their own and some other hospital. Sometimes these comparisons have but little meaning, because conditions are not the same. The best thing about the system is that it enables one to make a comparison between their own hospital of a few years ago and now; between their income and expense account of any month, or any year; with the present month, or the present year.

It is the same business spirit that prompted the organization of the Central Purchasing Agency in New York, which is of use in standardizing supplies, and which has possibly secured better prices for some articles, but which, more than anything else, demonstrated what good terms the hospitals had secured when acting as their own agent.

The same spirit should lead to watchfulness against the loss of money through the loss of time (for time is money), or through the lapping of the duties of employees.

It will be found conducive to the efficiency of each department, and of the entire hospital, and good business as well, to keep an accurate time record of every employee of

the hospital. About six months ago we installed a time clock by which each employee, including the superintendent, supervisor of nurses, and everybody down to the scrub-woman, is his or her own timekeeper, and practically determines the exact wage that he or she will receive. The head of each department also prepares a pay-roll for their department, and if their pay-roll does not agree with the time clock cards, explanations will be in order. Thus the time cards tone up not only each individual employee, but the department heads as well.

Another thing that will add materially to the economical management of each department is this. The superintendent should so plan his work that he can be his own purchasing agent. Nothing from a box of matches to an operating outfit should be ordered except over his signature. In a large institution this might seem impossible, but not so if he has a good secretary who has the business well in hand; has the prices previously paid; lists of goods purchased, and where.

Together with the purchasing should be considered the distribution of goods. In my hospital we have requisition slips with blanks for goods desired, and for the goods on hand of the same kind, and for the goods delivered. This requisition slip is signed by the head nurse, O.K.'d by the supervisor of nurses, and then sent to the storekeeper. When returned to a floor the head nurse signs for the articles received. Then the slip comes to my office, where the ward is credited with the goods received. The pharmacist has a similar method of keeping track of medicines. In this way we know where the supplies are going.

As to the financial loss which comes through breakage and waste, I can add but little to what we have heard many times. I think the plan adopted by many hospitals of insisting that all broken or worn articles, crockery, furniture, general and treatment utensils, must be returned with requisition for a new supply, is an excellent plan.

In order to keep a close watch over the waste, the plan which we are using is this. We have six receptacles for refuse in our crematory room. Each of these receives the refuse of different parts of the hospital, and is under lock and key. There is a daily inspection of these receptacles, and if anything improper comes down we know where it has come from, and act accordingly.

Dr. H. T. Summersgill, Superintendent of the New Haven Hospital, writes along the same line. He says: "I have found much waste can be prevented by routine inspection of broken crockeryware and other articles which have been condemned or broken. I have a room fixed up adjacent to the storeroom; in there is placed and labelled one good-sized barrel for each ward and each department. A hole six inches in diameter has been cut in the door so that the contents of these barrels can be observed from the outside. In these barrels are placed the breakage from each ward and each department, the one breaking the article being obliged to put label on it with name and date. If a nurse in charge of a ward has an unusual amount of breakage in a month, she is brought to account for poor management. If, on the contrary, a nurse has done very well and been careful in her management, she receives proper credit for it. All our instruments for ward dressings are now sterilized by steam in our operating-room building instead of the custom in use in most institutions where they are sterilized by gas in each ward."

Knowing the many-sidedness of hospital work, I thought I would like some of my friends to help me; accordingly, I addressed about one hundred members of this Association, asking them to give their fellow-workers the benefit of their experience by writing for this Round Table part of my paper any feature of their work which was particularly successful during the past year. This opened a wide door, as we in-



tended it should, and I received many exceedingly suggestive replies which I now bring to you in this Round Table part of my paper.

We have been discussing business methods of organization. Several of my correspondents have something of value to say concerning this subject.

Miss Louise C. Brent, Superintendent of the Hospital for Sick Children, Toronto, writes: "One of the successful features that has aided the efficiency of the hospital administration, is that each department has a head, who is responsible to the superintendent for the work of his, or her department, from the superintendent of nurses to the caretaker of the building. This may not be exactly a new feature, but we have found it an entirely satisfactory one.

Dr. Clarence E. Skinner, of the Elm City Private Hospital, also gives emphasis to the same fact which, he says, "conduces very greatly to the efficiency of service and economy of financial management."

Mrs. A. M. Lawson, Superintendent of the General Memorial Hospital, writes: "The fact that heads of our departments report to the superintendent, and not to committees, or sub-committees, makes the executive work run more smoothly."

Miss Nancy E. Cadmus, Superintendent of the Manhattan Maternity and Dispensary, speaking of the employment of a resident physician and his duties, says: "He is simply a head of a department the same as the principal of nurses, housekeeper, or engineer."

These quotations are sufficient, I think, to make clear the position of the superintendent in any efficient plan of hospital organization. He is the connecting link between the board of managers and each department of the hospital. If the board of managers treats him with the consideration that his position should have, he will be their representative in all details of administrative work.



From many letters it is evident that the nursing question is still open for discussion.

Dr. Renwick R. Ross, Superintendent of the Buffalo General Hospital, requests that we discuss the "special nursing of private patients twelve or twenty-four hour system." I suppose by right that should go to the question box, but I will say this. In my hospital we have no difficulty with the matter. When nurses are on private duty outside the hospital they frequently take twenty-four hour cases; whether in the majority or minority of cases, I do not know.

Now it is easier to nurse in the hospital than outside. The attending physician and supervisor of nurses determine whether the patient should be a twelve or twenty-four hour case. The nurse that will not take a twenty-four hour case under these condition will not be permitted to come in and take a twelve-hour case.

Others write concerning the scarcity of nurses, intimating that herein is a great hindrance to hospital efficiency, and these reports come from all parts of the country. Here in New York the difficulty is felt with very great keenness. The desire to improve the quality of nursing by securing for our training schools reasonably well-educated young women is appreciated by every one who has had occasion to have a trained nurse in his own family.

But the Board of Education in New York State, which has practically unlimited powers under a loosely-drawn State law, has pushed matters so far that the greater part of the hospitals in Greater New York City have memorialized the Board of Regents of the State protesting against the present methods of the Education Department in dealing with the hospitals of the city.

If other states are pressing matters as New York State is, it is easy to understand the reason for the shortage of nurses. The course in this State is legally two years, but those who prepare the curriculum believe in three years,

and in three years only, and prepare the curriculum accordingly. Now it is perfectly evident that many a girl falls out in the midst of her course because of the crowding which is necessary in order to master the various studies, even though she had three years to complete them.

Then again the demand which requires one year of high school, or its equivalent, places a premium upon the intellectually and physically unfit. Girls who are unable to pursue their studies beyond one year in high school fail for physical or intellectual reasons. As a rule, the grammar school graduate is the equal, and in some cases superior to the girl with one year of high school to her credit.

It was natural that superintendents should write concerning material improvements.

Mr. Asa Bacon, Superintendent of the Presbyterian Hospital, Chicago, tells of the expenditure of nearly \$800,000 in improvements, and no deficiency for four years.

Dr. W. T. Graham, Superintendent of the Methodist Hospital in Indianapolis, tells of the expenditure of \$125,000 in new buildings, and of plate glass partitions between each crib.

The Beth-El Hospital, of Colorado Springs, Miss Florence E. Standish, Superintendent, has expended \$35,000 in the erection of new buildings. The money was raised by issuing six per cent. bonds. Then an agent was put in the field to raise the money who is meeting with success. I notice she mentions a paid anæsthetist.

Mrs. Jennie L. Bassett, Superintendent of New Britain General Hospital, writes of a new operating building costing \$25,000, and of plans for a new private building. She asks: "Will some one kindly tell me the best finish for hospital floors; and how to prevent the awful waste of food from patients' trays?" I have read Mrs. Bassett's question chiefly because it illustrates for all of us the first essentials to efficiency—to detect and feel keenly the need of improvement.

The New York Hospital, Dr. Thos. Howell, Superintendent; The New York Society for the Relief of the Ruptured and Crippled, Mr. Oliver H. Bartine, Superintendent; The Presbyterian Hospital, are about to change their locations, and are planning for even larger things in the future than in the past.

The New York Post-Graduate School and Hospital, Dr. Fred Brush, Superintendent, is bringing to completion buildings which will increase their bed capacity from 200 to 400.

The Methodist Episcopal Hospital, in Brooklyn, N.Y., has recently spent \$100,000 in improvements.

The Indianapolis City Hospital, Dr. J. L. Freeland, Superintendent, is rejoicing over \$110,000 received from the city for new buildings. He also reports a legacy of \$225,000, and confesses to inside information as to \$700,000 more coming from a living donor.

There are only two things better than legacies—a gift during one's lifetime, so that he can have the pleasure of seeing it at work; or a gift upon which the hospital may pay a moderate annuity during the life time of the donor. Either of these methods will defeat the purpose of the legacy chaser—for there are legacy chasers as well as ambulance chasers.

The Rev. Geo. F. Clover, Superintendent of St. Luke's Hospital, this city, tells us of the appointment of nurses as anæsthetists at his hospital, and he adds: "We have gone far enough to feel that it is a step in the right direction."

They have also set apart a special building for the housing of the help in which each person has a small room. This arrangement gives satisfaction to a majority of the servants. "But," he states, "we have found, however, a few servants who felt so lonely and fearful over going to single rooms that they put in a request that they might be allowed to return to club rooms with several other servants."

Concerning floors he writes, and this may be of interest to Mrs. Bassett and others: "A combination tile and linoleum floor which I laid nearly a year ago has proven to be quite excellent, and it appeals to me as rather the best thing yet done in the way of flooring."

Dr. Wm. O. Mann, Superintendent of Massachusetts Homœopathic Hospital, Boston, tells of a new \$150,000 building for Clinical Research and Preventive Medicine. In this building there will be an auditorium for public lectures along the lines of preventive medicine. This, perhaps, might be considered unique in hospital work.

Miss Mary H. Riddle, Superintendent of Newton Hospital, Newton, Mass., writes: "This is one of the hospitals in which both schools of medicine practice without friction." Perhaps that might be a good cure for hospital friction."

Under the by-laws of the Methodist Hospital in Brooklyn all schools can treat their patients in our private beds. To treat surgical cases, it is necessary that outside physicians must be on the surgical staff of some reputable hospital.

Dr. A. W. Smith, Superintendent of Hartford Hospital, Hartford, Conn., writes: "We allow our staff or any reputable physician to send in cases to private rooms and take care of them."

Mr. Reuben O'Brien, Superintendent of the Manhattan Eye and Ear Hospital, says that nothing adds to hospital efficiency like an experienced woman in charge of the kitchen.

Miss Margaret Moran, Superintendent of the Macon Hospital, Macon, Ga., writes concerning the success of the newly installed signal light system. Any system that will do away with noisy call bells will soon find its way into all of our hospitals.

Dr. C. I. Fisher, Superintendent of the Presbyterian Hospital in this city, writes a most valuable letter concerning the relation of the Superintendent to the House Staff in regard to their relations to patients outside strictly professional mat-

ters. He says: "For many years I have taken note of the various incidents, accidents, etc., which have brought discredit to the hospital through the attitude and behavior of the House Physician and Surgeons. As soon as we have graduated our House Physicians and Surgeons and the seniors come to take their places, I get these men together and tell them about these things which have happened, how they discredit the hospital, and how they could and should have been handled differently.

The ambulance men have, through ignorance and sometimes over-confidence and lack of tact, caused us considerable trouble. I get these men together of an evening and tell them all the things that have happened, what surprises are likely to come to them, and show them how they can handle these and bring credit rather than discredit to the hospital.

The men who examine patients for admission to the hospital, have in themselves great possibilities for good or evil, particularly evil. I have an evening with these men, and tell them the things that have happened, and along what ilnes there are peculiar dangers in admitting or not admitting certain classes of cases. We have a good talk together, perfectly informal, and they ask me questions. I am sure that in these talks, I have saved the hospital a great deal, and prevented things happening which would have been exceedingly unpleasant.

I endeavor to accomplish similar things with our nurses, though not in quite the same way.

There is another question to which I would invite your attention. Dr. Fisher presented a paper on a very practical subject last year at St. Louis, and it seems to me we should not allow it to be forgotten. He made a plea for more ample provision for the great middle class who are neither rich nor poor. They do not wish charity, neither can they afford luxurious accommodation, nor large surgical fees



Here, however, is a danger: while the hospital may plan for this class of patients even at a loss, yet the surgeons' fee may be just as large as if the patient was cared for in a private room with a single bed. Indeed the fee may be larger because of reduced hospital charges.

Dr. Fisher well said that "it will be necessary to place about it such regulations as will safeguard it from any effort of the parsimonious rich to obtain use of these rooms, or of attending physicians or surgeons to put into them those wealthy patients who should pay the price of the more expensive service." The fees for these rooms should be very moderate and definitely fixed.

I think there has been no more practical deliverance than this for some time. And it seems to me that the matter should not be allowed to stop there. I wish that it might be taken up by our hospital journals and discussed, and that our superintendents might be prevailed upon to report through these journals their plans for the care of this class of patients, rates, fees, etc.

In bringing this paper to a conclusion permit me to congratulate the committee on the non-commercial hospital exhibit, on the excellent display which they have made, which I am quite sure will be conducive to economy and efficiency of hospital administration.

PRESIDENT: I am sure we are all very grateful to Dr. Kavanagh for his excellent resume of the work of the year in the different hospitals of the country. To me it has been very illuminating.



## REPORT OF COMMITTEE ON TIME AND PLACE.

Your Committee on Time and Place of Meeting beg to recommend that this Association meet Sept. 24, 25, 26, and 27, in the City of Detroit, Michigan.

R. R. ROSS,  
MARY L. KEITH,  
J. L. FREELAND.

On motion, the report of the Committee was adopted.

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## REPORT OF NOMINATING COMMITTEE.

Your Committee on Nominations beg to recommend the appointment of the following officers for the ensuing year:—

President—Henry M. Hurd, M.D., Secretary of the Board of Trustees, Johns Hopkins Hospital, Baltimore.

Vice-Presidents—A. J. Ranney, M.D., Superintendent The Lakeside Hospital, Cleveland, O.; J. L. Hudson, Esq., President Board of Trustees, Harper Hospital, Detroit, Mich.; Miss Nancy P. Ellicott, Superintendent of the Rockefeller Hospital, New York City.

Secretary—J. N. E. Brown, M.B., 522 Church St., Toronto, Canada.

Treasurer—Asa Bacon, Esq., Superintendent The Presbyterian Hospital, Chicago.

W. H. SMITH,  
F. E. MOULDER,  
WILLIAM DANT.

On motion of Dr. Smith, the report of the Committee was adopted.

PRESIDENT: Before we close I should like to thank the officers of the Association who have worked with me this year. Dr. Brown and Mr. Bacon have both labored at all time to advance the Association. I want to say that at this moment we have nearly 1,000 members. We have had over fifty applications here at this session, new applications which has brought the number up to that mark. I have had more pleasure, perhaps, than I might express now throughout four years of service for the Association. I anticipate being a worker among you on one of the back seats for years to come. I want to thank at this time many members of the Association who, on various occasions have assisted me as Secretary, and this year as President, in advancing the work of the Association.

It has been customary for the retiring President to introduce the President-elect. Dr. Hurd could not be present to-day. I want to congratulate the Association on the nominees. I want to say that you have elected as President for the coming year the dean of the superintendents of this country. Dr. Hurd has been superintendent of three hospitals, covering a period of forty-one years; he has been Superintendent of Johns Hopkins Hospital nearly twenty-one years. The nomination as President of this Association has been offered to Dr. Hurd many times and he has persistently refused to accept the office, because he thought he was too busy at Johns Hopkins Hospital. As Secretary of the Johns Hopkins Hospital Trustees he is in a position to devote time to the work that he thinks is necessary. I presume Dr. Hurd has supplied a larger number of superintendents of hospitals for the country at large than any other man. I do not think that that number can be counted on the fingers of two hands. There are many young men and men of middle age occupying positions in hospitals throughout the country that are proteges of Dr. Hurd. Many of you know of the great number of superintendents of train

ing schools that have gone out of Johns Hopkins in years gone by. I think that we are to congratulate ourselves on the man that we have selected to preside over this Association at the next convention and for the year to come.

DR. BRUCE SMITH: Before the Association adjourns I think it is only fitting that we should record some expression of the appreciation that each member of this Association, I sincerely believe, holds for our retiring President. For several years it has been my privilege to meet with the members of this Association at their annual gatherings. I have seen this Association grow from a comparatively small number to this convention this year, the largest hospital meeting that has ever been held in the world. The success of this meeting and the enlarged membership of this Association is largely due to the untiring efforts of Dr. Babcock while he was Secretary of the Association, and it was most fitting that the last year of his arduous labors and earnest efforts to promote the membership of this Association should be recognized in his election to the Presidency. I know I voice the sentiment of those who come from Canada in saying that we have found in Dr. Babcock one of the most energetic, and one of the most enthusiastic hospital workers that we have met anywhere, and I feel to-day that while there may be no reciprocity in fiscal matters, there is a union between hospital workers that no boundary lines can separate, that we are one in heart and one in aim, and I believe that in the membership of this Association we will all unite, and I am pleased that so many of us in Canada have the honor of belonging to this Association, now the greatest hospital association in the world, and that greatness is largely due to the efforts of our retiring President, for whom I move a vote of thanks be recorded in evidence of our appreciation of his earnest and faithful efforts. (Applause.)

THE SECRETARY: Ladies and Gentlemen: You have heard the motion, and I am sure there is only one reply to that. Those who are in favor will give a second clap. (Applause.)

PRESIDENT: I thank Dr. Smith and the Association very heartily. Is there any further business before the Association?

DR. E. B. SMITH: I should like to move a vote of thanks to a lady that has done a lot of quiet work for this convention, Miss Aikens, in arranging the exhibit.

Motion to thank Miss Aikens was seconded and carried unanimously.

Adjourned.

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*REPORT OF NON-COMMERCIAL EXHIBIT.**New York Post-Graduate Medical School and Hospital.—*

Sample of Asphaltazza flooring (first quality asphalt with stone chips).

Sample of lactoleum flooring (liquid linoleum) impervious to acids.

Sample of Lactoleum shelf.

Sanitary steel base designed for hospital use.

Sample of carrara glass for operating room walls.

Sample of tile wainscot with accessible round corners.

A patients' admission and signature book, releasing the hospital from responsibility.

A book of hospital statistics and comparative accounts.

An index record of treatment of X-Ray and electrotherapeutics.

New electric instrument sterilizer.

New electric incubator.

Combined bed rests, table, foot rest, protector.

Tunnel vent for facilitating the filling of bottles.

Comparative costs of manufactured tablets, and hospital made tablets.

New round steel table for holding infant bath tub and weighing machine.

New obstetrical table designed after experiments with wooden table.

New revolving chair with strap for nystagmus test.

Special combined table and desk designed for nurses' home.

*Mount Sinai Hospital, New York.—*

Stand and apparatus for subcutaneous and intravenous infusions.

Cardiac leaning stand.

Perineorrhaphy strap.  
Restraining sheet.  
Specimens of home-prepared catgut.

*St. Luke's Hospital, New York.*—

Dressing can with pedal attachment used in operating room.  
Bed seat for convalescent patients improvised by Dr. B. F. Curtis.  
Metal box with handle used in the wards for conveying dressings.

*Roosevelt Hospital, New York.*—

Laundry truck.  
Bed truck.  
Instrument sterilizer.

*Rockefeller Institute Hospital, New York.*—

Hospital bed.  
Back rest.  
Soiled clothes carrier.  
Bedside stand.  
Utensil rack.  
Set of woven names for marking hospital linen.

*Hospital for Ruptured and Crippled, New York.*—

Orthopedic apparatus, as follows, all of which are manufactured by the hospital:

- 1 Campbell brace.
- 1 long spring with pelvic band.
- 1 long spring with snap joint.
- 1 pair knock knee braces.
- 1 pair bow leg knee braces (caliper).
- 1 posterior knee brace.
- 1 Thomas knee brace.
- 1 Taylor spinal and chin piece.
- 1 Taylor spinal without chin piece.



- I pair double upright, stop joint.
- I pair bow legs, short.
- I Taylor hip splint.
- I Taylor club foot brace with pelvic band.
- I double truss—leather covered.
- I single truss—leather covered.
- I extension apparatus and plaster jackets.
- I chin strap for extension apparatus.
- 2 weights for bed extension apparatus.
- I steel hip rest.
- I head spring.
- I pair flat foot braces.
- I Whitman frame.
- I stocking—canvas.
- I knee lacing—canvas.
- I ankle lacing—canvas.
- I plaster corset.
- I plaster cast for flat foot braces.
- I bed cart (known as banana cart).
- I lead tape (leather covered).
- I abdominal belt with pad.
- I abdominal belt with corset back.
- I spica box.
- I plaster corset with head spring attachment.

*New York Hospital, New York—*

- 1. Suction apparatus with special suction nozzle.
- 2. Hypodermic tray. Catheterization tray. Cupping tray.
- 3. Rubber glove mending machine with special instrument for cutting patches.
- 4. Individual boxes for female children.
- 5. Cabinet of old-fashioned surgical instruments.
- 6. Harness ring.

*Manhattan Maternity and Dispensary—*

Equipped staff labor bog.  
Equipped nurses' post partum call bag.  
Equipped breast tray.  
Maternity bed—made as used.  
Long binder on doll.  
Breast binder.  
Abdominal binder.  
Private patient nightgown.  
Fundus belt.  
Ward nightgown.  
Post partum dressings.  
Door bumper.  
Cuffs.  
Leggings.  
Triangles.  
Weighting blankets.  
Jacket for premature infant.  
Infusion set.  
Ice cap cover.  
Post partum dressings.

*Presbyterian Hospital, New York—*

Child's examining table.  
Wire bed screen or grille.  
Improved bedside table.  
Roster board for training school.  
Key cone.  
Specimens of marked charts—medical and surgical.

*Jewish Hospital, Brooklyn—*

Baby's bed for maternity ward.

*Miserecordia Hospital, New York—*

Second stage labor suit.

*Chicago Lying-In Hospital, Chicago—*

Obstetrical knit leggings and jacket.

*Bellevue Hospital, New York—*

- Demonstration of methods of filing clinical records.
- Demonstration of social service methods.

*Hartford Hospital, Hartford, Conn.—*

- Demonstration of methods of misuse of hospital appliances—collection arranged for class teaching.
- Hypodermic tray.
- Specimen of blanks and printed matter.

*Youngstown Hospital, Youngstown, Ohio—*

- Model of chart cupboard for ward use.
- Specimens of printed matter.

*Baptist Sanitarium, Houston, Texas—*

- Photographic exhibit.

*F. F. Thompson Hospital, Canandaigua, N.Y.—*

- Home-made bed screens.
- Croup kettle.
- Crib-bed for mildly delirious adult patients.

*Massachusetts General Hospital, Boston—*

- Demonstration of methods of filing clinical records.
- Model of tent ward for children—18 beds and service rooms.

*Boston Consumptives' Hospital, Boston—*

- Device for caring for specimens of stools.

*Sydenham Hospital, Baltimore.*

- Croup kettle, with electric attachment.
- Specimen glass for laboratory.

*International Children's Garden League—*

- Model of children's garden.

*New England Baptist Hospital, Boston—*

- Model of tent ward and furnishings.
- Doll showing outdoor rainy day uniform for nurses.
- Demonstration of keeping bedside records.

*Corning Hospital, N.Y.—*

Home-made typhoid sponge.

Simple silencer for doors.

Method of arranging surgical dressings.

*Lincoln Hospital, New York—*

Demonstration of X-Ray work.

Occupations for blind patients.

*Samaritan Hospital Philadelphia—*

Proctoclysis apparatus.

*Watters Laboratories, New York—*

Milk siphon.

Washable canvas shoe.

*Ernest Wende Hospital, Health Department, Buffalo, N.Y.—*

Removable ambulance lining.

*Adams' Nervine Hospital, Jamaica Plains, Mass.—*

Occupations for patients.

*Rochester General Hospital, Rochester, N.Y.—*

Child's restraining waist.

*Winnipeg General Hospital, Winnipeg, Man.—*

Plans for nurses' home.

*Mr. Wilbur A. Bowen, Waterville, Maine—*

Demonstration of methods of raising money for hospitals.

*Presbyterian Hospital, Chicago—*

Economical liquid soap dispenser.

Economical alcohol dispenser.

Regulating cut-off device for rubber tubing.

Hypodermic needle sterilizing apparatus.

*Philippine Training School, Manilla, P.I.—*

Specimens of printed matter.

*New York Health Department Hospitals—*

Model of simple and economical disinfecting apparatus.

Specimens from anti-toxin laboratories.

*New York Milk Committee —*

Exhibit of charts, blanks, photographs, illustrating methods used in reduction of infant mortality work.

*Mr. Edward Stevens, Boston—*

Device for door in nurses' home used in Utrecht, Holland.

Plans for nurses' homes.

*Waterbury Hospital, Waterbury, Conn.—*

Envelopes for sterilizing dressings.

Kimono and skirt for convalescing patients.

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SOCIAL SERVICE EXHIBIT.

*Presbyterian Hospital, New York City—*

Photographs—Reports—Records.

*New York Hospital, New York City—*

Reports—Records.

*Brooklyn Hospital, Brooklyn, N.Y.—*

Sample record of case—Record cards.

*Boston Dispensary, Boston, Mass.—*

1 wall chart—Sample records.

*Bellevue and Allied Hospitals, New York City—*

Paintings illustrating social service—Wall chart—

Reports—Sample records of cases—Sample blank records, etc., used in social reform office.

*Massachusetts General Hospital, Boston—*

1 wall chart—Reports—Sample records of cases—Sample blank records, etc., used in social service office.

1 set of reference cards filled out.

*Johns Hopkins Hospital, Baltimore, Md.—*

8 frames containing sample records of cases.

## DEPARTMENT OF PUBLIC CHARITIES N.Y. CITY.

*King's County Hospital, Brooklyn, N.Y.—*

Photographs—Sample records of cases—Sample blank records, etc., used in social service work—  
Sample of appeals used by committees.

*Metropolitan Hospital, Blackwell's Island—*

Photographs—Sample records of cases—Sample blank records used in social service work.

*City Hospital, Blackwell's Island—*

Photographs—Sample records of cases—Sample blank records used in social service work.

*Cumberland St. Hospital—*

Reports.

*Randall's Island Hospital—*

Reports.

*Sample Blank Records used in Social Service Dept., from—*

Roosevelt Hospital, N.Y. City.

Cambridge Hospital, Cambridge, Mass.

Memorial Hospital, Worcester, Mass.

Brooklyn City Dispensary, Brooklyn.

Berkeley Infirmary, Boston, Mass., also reports.

Homeopathic Hospital, Rochester, N.Y.

Vanderbilt Clinic, New York City.

Carney Hospital, Boston, Mass., also reports.

Children's Hospital, Boston, Mass.

Montefiore Home, New York City.

University of Pennsylvania, Philadelphia, Pa.

Union Hospital, Fall River, Mass.

Buffalo General Hospital, Buffalo, N.Y.

St. Louis Children's Hospital, St. Louis, Mo.

Presbyterian Hospital, Philadelphia, Pa.

Pennsylvania Hospital, Philadelphia, Pa.

Mt. Sinai Hospital, New York City.

New York Infirmary for Women and Children, New York City.



Marie Celeste Society, London Hospital, London, England.

The following hospitals contributed specimens of hospital blanks and printer matter:

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## FIRST ANNUAL CONFERENCE.

THE ASSOCIATION OF AMERICAN HOSPITAL SUPERINTENDENTS.

Organized at Cleveland, O., Sept. 12 and 13, 1899.

The meeting was called to order by Jas. S. Knowles, Superintendent, Lakeside Hospital, Cleveland, O.

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